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# FRAUD AND ABUSE IN EMPLOYER SPONSORED HEALTH BENEFIT PLANS

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## HEARING

BEFORE THE

PERMANENT
SUBCOMMITTEE ON INVESTIGATIONS

OF THE

COMMITTEE ON
GOVERNMENTAL AFFAIRS
UNITED STATES SENATE

ONE HUNDRED FIRST CONGRESS

SECOND SESSION

MAY 15, 1990

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# FRAUD AND ABUSE IN EMPLOYER SPONSORED HEALTH BENEFIT PLANS

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TUESDAY, MAY 15, 1990

U.S. SENATE,
PERMANENT SUBCOMMITTEE ON INVESTIGATIONS,
COMMITTEE ON GOVERNMENTAL AFFAIRS,
*Washington, DC.*

The Subcommittee met, pursuant to notice, at 9:00 a.m., in room SD-342, Dirksen Senate Office Building, Hon. Sam Nunn, Chairman of the Subcommittee, presiding.

Present: Senators Nunn, Lieberman, and Roth.

Staff present: Eleanore J. Hill, Chief Counsel; John F. Sopko, Deputy Chief Counsel; Mary D. Robertson, Chief Clerk; Cynthia Comstock, Staff Assistant; David Buckley, Chief Investigator; Alan Edelman, Counsel; R. Mark Webster, Investigator; Grace McPhearson, Investigator; Kimberly O'Dell, Staff Assistant; Daniel F. Rinzel, Chief Counsel to Minority; Carla Martin, Assistant Chief Clerk to Minority; Blaine Phillips, Staff Assistant to Minority; Aaron Bayer [Senator Lieberman]; John Nakahata [Senator Lieberman]; George Eliades [Senator Rudman]; Kim Corthell [Senator Cohen]; and Ellice Halpren Barnes [Senator Stevens].

[Letter of authority follows:]

U.S. SENATE,
COMMITTEE ON GOVERNMENTAL AFFAIRS,
*Washington, DC.*

Pursuant to Rule 5 of the Rules of Procedure of the Senate Permanent Subcommittee on Investigations of the Committee on Governmental Affairs, permission is hereby granted for the Chairman, or any Member of the Subcommittee as designated by the Chairman, to conduct open and/or executive session hearings without a quorum of two members for the administration of oaths and the taking of testimony in connection with hearings on the Fraud and Abuse In Employer Sponsored Health Benefit Plans on May 15, 1990.

SAM NUNN,
*Chairman.*
WILLIAM V. ROTH, Jr.,
*Ranking Minority Member.*

## OPENING STATEMENT OF SENATOR NUNN

Senator NUNN. The Subcommittee will come to order.

This morning the Permanent Subcommittee on Investigations will examine the problem of fraud and abuse in employer sponsored health benefit plans. At a time when the financing of America's health care system is already in critical condition, the type of fraud which we will hear about today is straining that system in ways which we as a Nation cannot afford to bear. This country spent almost $600 billion on health care last year, a figure which represents over 11 percent of our gross national product. This figure also represents a 700 percent increase over the amount spent on health care just 20 years ago.

As medical costs continue to skyrocket, some form of health insurance has become more and more of a necessity in order for the average American to afford health care. And yet in America today between 31 and 37 million Americans have no health insurance at all. Perhaps even more shocking, of those Americans who are uninsured, over 19 million are working men and women. That represents approximately 14 percent of our Nation's work force. The vast majority of these working uninsured are concentrated in small companies and in industries characterized by seasonal, temporary, or lower skilled work forces.

Why do so many working men and women lack any type of health care plan? Quite simply, because many small companies cannot afford the high cost associated with an employer sponsored plan. According to one report, rates for employee health insurance policies have increased 30 to 35 percent a year for the past 2 years. Indeed, a recent survey done by an international consulting firm has estimated that by the end of this year the average employer's medical benefit costs will have increased to more than 13 percent of the payroll. And for most small employers the costs are even greater, both in terms of premiums paid and administrative costs incurred.

In the face of these costs, those small employers who do seek to provide their employees with a health benefits plan are desperate to find a plan they can afford. In their desperation many of these employers end up being taken in by slick operators who promote multiple employer plans as a way of reducing costs. From all outward appearances, these plans seem to be perfectly legitimate. They are often marketed through local insurance agents and often appear to be affiliated with major insurance companies. In reality, however, many of these plans are nothing more than sophisticated pyramid schemes in which the ability to pay the claims of existing participants depends on the ability to attract more and more participants and thereby obtain more and more premium dollars.

At the same time though, many of these plans are being looted by unscrupulous operators who use premium money to cover outrageous salaries and commissions, personal expenses and entertainment. After they have bled the plan dry there is often little or no money to pay off the participants' claims. By the time anyone has caught on to this scheme, the operators have usually skipped town, often moving into another State in order to avoid the reach of State insurance authorities. In their wake, these con artists leave behind men and women who thought they had health insurance, but who now find they have nothing more than a mound of unpaid medical bills.

In one case in Texas a promoter left a plan with $7 million in unpaid claims. Another pair of promoters operating plans in California, Texas and Florida left over $10 million in unpaid claims. Left behind are people like Patricia Gonzales of San Antonio, Texas, a bank employee whose baby daughter was born last year with multiple congenital defects. Ms. Gonzales thought that the health benefits plan she had through her job would take care of her daughter's hospital bill. As it turns out, the promoter of her health plan, Rubell Helm Insurance Services, Inc., has been shut down by three different States for operating an illegal insurance operation. Ms. Gonzales estimates that the medical bills for her daughter, who has spent practically her entire life in the hospital, are now over $340,000.

In addition to the hoax perpetrated on those who find themselves liable for huge unpaid medical bills, is the hoax perpetrated on those who find themselves unable to obtain new insurance because they now have preexisting medical conditions. Individuals such as Robert Wagner and Fred Smith, each of whom we will hear from today, find themselves not only uninsured but also uninsurable.

Unfortunately though, these tragedies are not new. In 1974 Congress passed the Employee Retirement Income Security Act, commonly known as ERISA. Under ERISA the Department of Labor was given the sole authority to regulate employee benefit plans. Shortly after the passage of ERISA, many States began reporting problems with promoters of fraudulent health plans who were taking advantage of the doctrine of Federal preemption under ERISA to evade regulation by State insurance authorities. In response to these problems, Congress amended ERISA in 1983, permitting the States to exercise jurisdiction over multiple employer plans under their insurance laws, in addition to the jurisdiction exercised by the Department of Labor under ERISA itself.

For many reasons, however, ambiguity over the exact jurisdictional boundaries between the States and the Federal Government has continued to this day, allowing the promoters of fraudulent plans to operate in a twilight world somewhere between State and Federal regulation, often playing one set of regulators off against the other.

We as a nation cannot allow this situation to continue. We pay too much already for health care costs. We cannot afford to have those costs driven up even more as a result of the medical community's need to recoup bad debts left by fraudulent health plans. Small employers have too few alternatives already for providing their employees with health care coverage. They cannot afford to have legitimate insurance companies driven out of the market by the low ball practices of fraudulent health plans that later go bankrupt.

We already have too many people in this country who are uninsured. We cannot afford to add to that number as a result of individuals left uninsurable by fraudulent health plans. I hope that through these hearings we can identify where the problems lie with this system so we can start taking the steps necessary to solve these problems at the state level as well as the Federal level, and I think we have to lead the way at the Federal level.

The hard working men and women of this country who pay their insurance premiums with every paycheck deserve to know that they have in fact purchased some protection for themselves.

In closing I would like to thank Senator Roth and his staff, members of the minority staff, for their cooperation and support in this investigation and we look forward to continuing to work together with them in making sure that the working men and women of America do in fact get the protection they deserve.

Our first panel this morning—and I will call all of them to come up—have been very helpful to us in working through this problem and we would like to thank each of you individually for your attendance here today and also for your tremendous help in helping us prepare for these hearings.

Mr. Jim Long is vice president of the National Association of Insurance Commissioners, Jo Ann Howard, member of the Texas State Board of Insurance, and Tom Gallagher, Commissioner, Florida State Department of Insurance.

We swear in all the witnesses before this Subcommittee, that is one of the rules of the Subcommittee, so before you take your seat I will ask all of you to hold up your right hand and take the oath.

Do you swear the testimony you give before the Subcommittee will be the truth, the whole truth and nothing but the truth so help you God.

Mr. JIM LONG. I do.

Ms. HOWARD. I do.

Mr. GALLAGHER. I do.

Senator NUNN. Mr. Long, I believe you are going to lead off this morning. We welcome you here and again, thank you.

Mr. Long is the vice president of the National Association of Insurance Commissioners and North Carolina State Commissioner. Of course, I have also introduced Jo Ann Howard, a member of the Texas State Insurance Board, and Tom Gallagher, Florida State Insurance Commissioner.

These witnesses will share with us their experiences in dealing with fraud and abuse in multiple employer health plans operating in their states, as well as their concern about the need for greater regulation of these plans.

Mr. Long, I believe you are going to lead off this morning.

## TESTIMONY OF JAMES E. LONG, VICE PRESIDENT, NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS [1]

Mr. JIM LONG. That's correct, Mr. Chairman, and thank you very much. We applaud your interest in this very vital subject, Mr. Chairman, and let me begin this just introduce myself to you. As you mentioned, Mr. Chairman, I am Jim Long, the insurance commissioner for the State of North Carolina. I also serve as vice president of the National Association of Insurance Commissioners. So Mr. Chairman, I would be remiss if I didn't point out to you a couple of other ties that I have, not only with you but with this Subcommittee.

One thing, Mr. Chairman, I am always known in my State for wearing the red galluses, and I think there was a Senator from your State who did that for a number of years, and I do it only to match the red tie and serve as the fire marshal, as your commissioner does. And also, I might point to you, Mr. Chairman, as a matter of historical interest, the widow of Senator McClellan of Arkansas who first founded this committee lives in my State, so I just bring that to your attention.

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[1] See p. 89 for Mr. Long's prepared statement.

Senator Nunn. Senator McClellan was an outstanding chairman of this committee for many years.

Mr. Jim Long. No question about it, and I hope Ms. McClellan continues to vote for me. I, by the way, am elected, Mr. Chairman, as you are, and as Commissioner Gallagher is, and to we have to run in Statewide elections so we understand the politics of it.

I would mention to you, Mr. Chairman, that as many times as I have been in Washington in the last 3 years testifying on the RICO hearings on racketeering issues, I have never been sworn in before a Committee before and it makes me a little nervous to be sworn in this morning, but I will try get through that.

The NAIC, Mr. Chairman, was asked by your Subcommittee to describe MEWA's, how they fit into Federal and/or State regulatory systems, and provide you a State regulator's perspective on the problems that the current dual regulatory system and intergovernmental and interagency cooperation are posing. I might as a side note to this, Mr. Chairman, point out to you that Ray Maria, who you will hear from later, from the U.S. Department of Labor, has really been a shining light in this process in working with the States, and for the first time in years we feel like we are starting to get some progress made in these problems that you have outlined.

In the written testimony I have already submitted to your Subcommittee, Mr. Chairman, I tried to provide an overview of the current ERISA law and some historical perspective, and I will not go into those in depth in the time allocated. But let me simply emphasize to you that the current ERISA law is so complex and so ambiguous, and it is complicated, of course, by widely divergent judicial, regulatory and industry interpretations, that it invites the entrepreneurs, the predatory operations, and even fraud. It further protects such operators from needed regulatory or legal redress due to questions of jurisdiction.

Now, while I am this morning in my dual role of representing both the State of North Carolina and the NAIC, most observations I will bring to you, Mr. Chairman, are based on the rather painful experiences in my own State, and you do have witnesses from my own State later who have been victimized by some of these schemes.

I am capably joined by my distinguished colleagues this morning from both Texas and Florida, and in written form, Mr. Chairman, from your own great State of Georgia. Your Subcommittee staff has assembled good examples of the kinds of problems that we are facing in the States.

My message to you here today is that the States can and will regulate MEWA's and any other health payment arrangements in the best public interest if Congressional intent can be reaffirmed, the confusing jurisdictional questions resolved, and more timely and supportive participation by Federal agencies involved—primarily the Department of Labor, especially the Pension and Welfare Benefits Administration, and the Internal Revenue Service can be forthcoming.

In many respects the current situation is reminiscent of the events of a decade ago which prompted the Congress in 1983 to tighten up the regulatory loophole extended to self-funded multiple employer plans. Facing dramatically escalating health insurance costs, a deteriorating regulated market, and the desire to avoid State laws such as premium taxes, mandated benefits, fair claims payment standards and minimum solvency requirements, the employers turned to self-insurance and pay-as-you-go arrangements as lower cost, alternate ways to fund benefit plans. The small employers sought these same cost avoidance techniques often by turning to third party entities which promised to provide plan administration for a number of small groups.

Many of the abuses in the multiple employer trust area which led to the Erlenborn Amendments of 1983 are being seen again, this time under the MEWA label. What became apparent in the hearings about the abuses visited on the small employer community in the late 1970's and early 1980's is again being dramatized a decade later. Jurisdictional regulatory ambiguities invite entrepreneurial if not fraudulent alternatives. Many small employers lacking the expertise and desperate to deal with plan costs, are turning to these arrangements on the erroneous assumption that they are safe, either regulated by the insurance department, or adequately protected under Federal law.

Too frequently, after the loss of thousands of dollars, these small businesses, their employees and their families, learn the painful truth that many such plans were deliberately designed to avoid State regulation and yet were never subject to any meaningful Federal oversight. Perhaps even more painful, Mr. Chairman, is the lesson that the only recourse most beneficiaries have against defunct ERISA health plans is either civil litigation or awaiting the final outcome of some bankruptcy proceeding.

For the average worker being pressed by a health care provider to pay health care bills they thought were covered by an employer's plan, neither the additional expense of litigation nor the delays inherent in civil or bankruptcy courts are feasible.

I would also note, Mr. Chairman, as was reported in the May 7, 1990 issue of Business Insurance, even the commercial insurance carriers like Travelers, medical service plans like Blue Cross and Blue Shield, and veteran insurance agents and brokers have been harmed by fraudulent operators exploiting the current legal, regulatory, and jurisdictional ambiguities in ERISA.

Mr. Chairman, there is a story, if you would have your staff furnish you this, in the May 7 issue of Business Insurance. Let me summarize from the story, Mr. Chairman, even though I assume that I am protected by congressional immunity, this is one out of my State and I don't want to get into details because we have it under investigation.

Cap Staffing so far has taken the Travelers Insurance for $860,000 of claims paid, has $1,300,000 in outstanding claims. These are the victims you are talking about, Mr. Chairman. These are not just raw numbers, these are people who have been harmed, who can't get the needed medical treatments that they deserve.

This Cap Staffing plan was set up under MEWA, under the guise of an employee leasing operation. It did sell insurance products. I would just ask you, Mr. Chairman, if you will turn to the May 7 issue of Business Insurance for further details on that. I would rather not go further in depth on that on the public record, sir.

But in short, Mr. Chairman, it is bad enough that many of these individuals and small business cannot afford needed health insurance in this country. It is deplorable that the legal questions, the regulatory tentativeness, or the lack of intergovernmental cooperation might lead to the loss of other precious health care dollars via fraudulent actions or mismanagement of small employer welfare plans.

Among the questions or issues this Subcommittee and/or other committees should examine in the course of your deliberations are: One, the implications of maintaining two different regulatory frameworks for employee health plans. The current ERISA language deters States from applying creative market-based alternatives, like high-risk pools aimed at addressing the twin problems of availability and affordability of health coverage; two, ERISA for both multiple and single employer plans needs to have a more meaningful safety net for harmed individuals. Seeking legal redress or awaiting final distribution at bankruptcy proceedings is certainly inadequate; three, don't weaken the civil applications of RICO. It is one of the few effective tools for recovering resources to pay beneficiary claims in fraudulent employer benefit arrangements. We use it in our State. The other States here represented use it in other cases too; four, in the absence of extending State regulatory protections, Congress must afford the beneficiaries of self-insured plans recourse in claims disputes, benefit interpretations, reasonable payment timeframes, and clear understanding of coverage, plus a single recognized Federal agency to which they can turn; five, the state definitions of employer/employee must be clearly addressed. Our painful experience with some employee leasing arrangements, such as Cap Staffing I reference, suggests this clearly needs to be examined to avoid further abuses; six, similarly, several questionable union plans which we are seeing suggests that the Taft-Hartley plan exemption for State oversight might be reexamined. Otherwise I fear the legitimate collectively bargained union plans may suffer from unnecessary adverse publicity; seven, the need for a central point of registry for all ERISA-qualified health plans must be addressed, along with requiring registration prior to the authority of any plan to begin operations. Mr. Chairman, it is too late for us to shut them down when they have been in operation 3 to 6 months; eight more effective ways to seek out bad operators and eliminating the apparent time lag between the examinations and processing plan records by PWBA and IRS; nine, either Congress or the Department of Labor should require the Form 5500 for all employer plans, not just those of over 100 employees. Too often it is the small employers that are hurt the most with their small payrolls; ten, finally, the State regulators, the insurance commissioners must have clearer declaratory opinions or interpretive rules from the Department of Labor as to what is and is not subject to State regulation.

Mr. Chairman, it is on this last point that I make the strongest plea. While the recent interest and support for State enforcement efforts by Labor's Inspector General Office is gratifying, this comes on the heels of years of delayed case-by-case opinion letters rather than a broadly applicable rule or direction by which regulators and administrators alike could resolve many jurisdictional ambiguities.

It is this apparent reluctance, and the result and uncertainty, that has, I am afraid, caused some of my State regulator colleagues to concentrate more on areas where we do have the clear authority.

It is the same ambiguity, unfortunately fanned by some business and trade associations' misinterpretations of the current ERISA language, that has prompted strong resistance to State oversight, even by the more responsible administrators of such plans.

My feeling, Mr. Chairman, is that once Secretary Elizabeth Dole, who I might proudly note is a native North Carolinian, is given the opportunity and congressional impetus, she can and will enjoin her staff to avoid further delays and ambiguities and to work with the task force of NAIC in setting up more effective central registry of ERISA plans as well as a meaningful data exchange. All of this can be done under the current ERISA language while Congress deliberates needed statutory changes.

Thank you, Mr. Chairman.

Senator NUNN. Thank you, Commissioner Long. I guess we will go to Ms. Howard next, and then Mr. Gallagher, and then we will come back for questions.

Jo Ann, we are glad to have you with us this morning.

## TESTIMONY OF JO ANN HOWARD, MEMBER, TEXAS STATE BOARD OF INSURANCE [1]

Ms. HOWARD. Thank you, Mr. Chairman. I am a member of the Texas State Board of Insurance, as you have noted. Fraudulent multiple employer welfare arrangements, or MEWA's, as you have aptly noted in your introductory statement, Mr. Chairman, are a toxic side effect of a larger national illness, our inadequate system for paying for health care in this country. Our current system leaves too many Americans desperately searching for affordable, available insurance coverage, and this environment is tailor-made for swindlers.

Fraudulent self-funded MEWA's have rushed to fill what amounts to an insurance vacuum in this country, and the promoters have no qualms from a taking the hard-earned dollars of employers and employees, these unsuspecting workers who think they are buying health coverage. They beguile the unsuspecting with low and actuarily unsound prices, willing to take all comers regardless of their medical conditions.

Consider a few more examples other than the ones you have been given. A pastor of a small church owes $200,000 in claims not paid by the Christian Organization Medical Society for his baby born with undeveloped lungs. He was threatened with removal of the baby's alarm respirator for nonpayment of bills. The minister has lost his home, car, job, and wife, and has openly contemplated suicide.

A laborer suffering from diabetes and heart disease can no longer work. He owes $130,000 which was not paid by the Rubell-Helm MEWA. He gets dialysis only now through charitable contributions.

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[1] See p. 110 for Ms. Howard's prepared statement.

Mr. Chairman, I was going to use the example which you gave of the woman in San Antonio. We know that her emotional trauma is compounded by the knowledge that much of her medical bills will not be paid because she too was part of the Rubell-Helm MEWA.

Where does the money go if it doesn't go to pay claims? You see the chart here beside me. From the Church Workers Health Plan, Bobby Earl Browning took a salary of $95,000 a month and used plan money as his exclusive personal property to pay for airplanes, estates, expensive cars, and eventually left the health fund with $4.5 million in unpaid claims. When the Texas State Board finally arrived and obtained a court order to take control of Browning's company, there were only $50,000 in assets left.

Mike Rubell and Jim Helm took at least $40,000 each month in salaries from their MEWA while claims were unpaid and claims files were shredded. Workers' contributions for health coverage were, again, spent on jewelry, tailor-made suits, luxury cars, servants, and even personal credit card bills. These swindlers we are talking about foster an impression that their criminal schemes are insurance companies. Then, when confronted by State regulators, they hide behind the Federal Employee Retirement Income Security Act, or ERISA, of 1974.

This, unfortunately, is not a new problem, Mr. Chairman and members of the Subcommittee. In 1972—and I have the testimony here with me—the Texas State Board came before the Subcommittee on Labor about the need for legislation to deal with MEWA's. Eight years later we are still debating how to halt the abuses inflicted by these fraudulent plans. More than $19 million in known claims have gone unpaid in Texas alone, yet nothing has been done to fill this regulatory black hole that is an open invitation to swindlers and confidence men.

I am very impatient here before you today because new schemes are multiplying right now like cancerous cells. Some might view this as an academic exercise, finger pointing or a turf battle, but it is none of these. Flesh and blood human beings are being hurt every day. Thousands of Texans alone are hurt. Only the amounts and names are different. ERISA has created a witches' brew of nonregulation and limited oversight that leads to buck-passing and inaction.

Let me illustrate quickly the present framework of Federal and State insurance regulation. The blue areas on the chart indicate Federal regulatory authority, the white areas are the States' scope of regulation. Notice as we go through this, please, how ERISA creates a complex pattern in place of simply leaving all health care regulation to the States.

Before ERISA, McCarran-Ferguson gave the States complete authority to regulate the business of insurance within their boundaries, but under ERISA's preemption language the Federal Government regulates self-funded employee benefit plans and exempts them from State regulation. However, the savings clause in ERISA permits State laws to control if they directly regulate the business of insurance. ERISA also has a "deemer" clause, which means that States cannot deem employee benefit plans to be insurance.

The Erlenborn Amendment of 1982 modified ERISA preemption. It authorized State authority to require that insured multiple employer welfare arrangements that are bona fide plans maintain both reserves and contributions, and it granted States full regulatory authority over self-funded MEWA's if they fit into the ERISA definition. However, the Erlenborn amendment does not provide any weapons against illegal MEWAs, which are fake ERISA plans.

Finally, States cannot regulate employee benefit plans operated under collective bargaining agreements or rural electric co-ops. The reason I brought this chart today was to show you how the regulatory authority goes back and forth between State and Federal lines in ERISA. As you can see, the MEWA ball lands in our State court, but the problem is that with ERISA, Congress expanded the lines nationwide and individual States simply cannot deal effectively with such an immense interstate problem. State regulators therefore find themselves at a masquerade ball with MEWAs costumed as various kinds of ERISA-sanctioned employee plans. These MEWAs don't assent to our authority, and in fact, they vigorously resist it, claiming they fall not within this white circle of MEWAs, but instead fall within the larger ERISA-preempted area, out of States' reach. We must then prove to a judge that our State can take action.

How do regulators tell the fake and phonies from those plans with legitimate claims to ERISA preemption? The answer is: they can't. And here is the biggest weakness of the system. No one licenses or certifies these plans, which are creatures of the Federal Government. We must rely on advisory opinions from the Department of Labor's Pension and Welfare Benefit Administration. To get one, a State regulator has to assemble the documentation on which the opinion will be based. Opinions are painfully slow in coming. Texas, Oklahoma, California have waited more than 5 months on an opinion on an operation that claims ERISA preemption. The PWBA opinion letters often leave waters as murky as before. In at least two instances, the PWBA's advice to Texas employers asking about particular MEWA's was, "Talk to the Texas State Board of Insurance."

Ultimately, our main weapons are injunctions and civil penalties, but our investigations are hampered by the fact that our jurisdiction is limited to our State lines, while MEWAs most often are interstate creatures. While investigations and civil litigation drag along, a fraudulent MEWA is a ticking time bomb for consumers. Its promoters do everything they can to slow the process because MEWA's are lucrative "Ponzi schemes" where today's bills and claims are paid with money arriving in tomorrow's mail. Meanwhile, delays in investigation and the judicial process enable these criminals to recruit more victims and collect more contributions.

As to solutions, Mr. Chairman and members of the Subcommittee, frankly, I don't believe that a State will ever develop a system for providing an adequate health benefit framework for all its citizens until all health coverage within its borders is under that State's exclusive jurisdiction. However, if Congress intends to continue offering businesses the option of self-funding their employee benefit plans, certain steps should be taken to protect the small employer and expedite justice for the criminals.

Our written statement offers in much more detail our recommendations, but let me mention a few of the most important. Certification or licensure by a Federal agency should be required before a plan or trust could claim ERISA preemption. States should be given clear authority to require production of documents and other materials bearing upon an entity's claim to be a valid ERISA plan. Civil litigation is ineffective in dealing with professional outlaws. We obtain civil judgments which go uncollected because the premium assets have already been taken out of State. In too many cases we just chase the fraud to an adjoining State.

Only criminal prosecution and jail time will stop the crooks who perpetrate these frauds. It is the Federal agencies that have the interstate jurisdiction and technical proficiency to conduct the kind of criminal investigations necessary. I support the recently introduced legislation which would enable Labor's Inspector General to increase his substantial enforcement contributions in this area.

In my home State, it is our intent to regulate all insurance sold to Texas consumers the way we string barbed-wire fences: horse high, bull strong, and pig tight. In this effort, we are hear today asking for your help.

Thank you very much for your attention in this matter. If either I or our staff can help you or give you more information, we would be very happy to do so.

Senator NUNN. Thank you very much, Ms. Howard.

Mr. Gallagher.

## TESTIMONY OF TOM GALLAGHER, COMMISSIONER, FLORIDA STATE DEPARTMENT OF INSURANCE [1]

Mr. GALLAGHER. Thank you, Mr. Chairman, and I appreciate you inviting us to speak here today.

In my opinion, the State of Florida is a laboratory for the Nation on insurance issues because of our demographics, rapid growth, a majority of small businesses, and increasing international population, and one in which one out of five citizens is elderly.

At a time when the Nation as a whole is wrestling to make health care benefits affordable and available, Florida is home to virtually every benefit alternative now being explored. You could say that we have a lot of experience with the good, the bad, and the ugly when it comes to insurance. One of those alternatives, of course, is the multiple employer welfare arrangements, also known as MEWA's.

In general, it is our philosophy that we should encourage in Florida a diversity of health benefit options. We want as large and creative a marketplace as possible, as long as the consumers who purchase these benefits are protected from fraud, from misrepresentation, and, of course, from insolvencies. We believe they should have as many options to choose from as possible. We encourage consumers to shop around and choose health care benefits that meet their needs and their pocketbook.

MEWA's have been represented as a viable and less expensive health care benefit alternative to insurance or membership in an HMO. MEWA's, it is claimed, make these benefits available and affordable to many Floridians, especially those in small businesses.

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[1] See p. 133 for Mr. Gallagher's prepared statement.

Such a claim is intriguing in a State where more than 90 percent of the businesses are small, employing fewer than 25 workers. And there are some MEWA success stories. We have, for example, three authorized MEWA's currently operating in Florida which have provided benefits to thousands of Floridians and their families with few consumer complaints. And all three show a positive net worth.

At a time when nationally consumers are finding these benefits to be increasingly expensive and hard to buy, the achievement of these MEWA's is important. They are delivering needed benefits to their certificate holders. Unfortunately, the overall picture in Florida is less favorable. It is our conclusion that dual regulation, which in some cases and at some points in time has actually been dual nonregulation, has resulted in extreme hardships to many consumers. Consider, in the 7 years following ERISA's enactment by Congress in 1974, the Florida Department of Insurance detected more than 25 health programs which claimed to be ERISA employee welfare benefit plans that were in fact unauthorized insurers.

A total of seven of these programs became insolvent, leaving Florida policy holders with millions of dollars in unpaid claims. While the 1982 Erlenborn-Burton Act gave the States limited authority to regulate MEWA's, this regulation has not fully protected consumers. Florida passed its MEWA law immediately thereafter, and has since strengthened it. Unfortunately, by then the industry had built allies to resist stricter regulation, and many in this industry have relied on its ambiguous identity, subject to neither Federal regulation nor State laws, to camouflage themselves from effective regulation.

And finally, while authorized MEWAs have a bad track record in Florida, the unauthorized bogus operations are even more insidious. They come into our State selling health insurance at what they say is a cut-rate price, but what they are really selling is illegal insurance offered by a company that is not licensed to do business in Florida, and they do this by throwing up a smokescreen that they are federally sanctioned ERISA's.

They thrive on confusion, and the consumer is the victim. Florida consumers have been victimized by a host of health plans with two things in common—the plans all refused to admit that they were subject to State regulation and they all left Florida consumers with unpaid health care claims. For example, Professional Wrecker Operations of Florida health and welfare benefit plan was self-funded and claimed an ERISA preexemption. It left unpaid claims of at least $200,000 before it went out of business in 1987. A few years ago the Christian Medical Association began enrolling Florida residents in a group plan. The group targeted ministers, churches, and church schools. It also left insurers with unpaid claims before Texas and other States were able to terminate its operation. Another administrator, Mark I Benefits, began enrolling Florida residents in the International Employers Benefit Trust. This group health plan was open to all industries.

Our department worked with the Texas insurance officials to close this operation down, but we weren't successful before the trust became insolvent, leaving insurers with unpaid claims.

Rubell-Helm insurance services is another example. I have attached to my written testimony a detailed outline of Florida's experience with this outfit. In brief, the company began enrolling Florida insureds in a self-funded, California-based MEWA in 1988. Rubell-Helm first claimed to be a fully insured ERISA plan when in fact no insurer provided coverage. Later Rubell-Helm stonewalled both Florida and California regulators, claiming to be a self-insured ERISA plan exempt from State regulation.

Under this guise, they signed up about 4,000 Florida insureds in a plan which ultimately left unpaid claims balance of $3.2 million. The corporation is now dissolved with no identifiable assets. The principals in the company cannot be located by the Department. We have referred the case to Federal investigators.

Since Rubell Helm, we have discovered the operation of several other multi-State unauthorized MEWA's providing group health coverage. Their standard defense is to challenge our jurisdiction. In addition, we are investigating several group insurance plans sponsored by organizations which claim they are exempt from state legislation as Taft-Hartley labor unions. For example, the Consolidated Labor Union, Local 867, marketed a plan in Florida underwritten by Empire Blue Cross-Blue Shield of New York. It appears that the premium paid by the insureds under this plan passes through a complex series of transactions with sales costs paid in Florida, Arizona, and New York before the premiums reach the insurer, if they do at all. Empire is not authorized to do business in Florida. Why is this important? First, there are no guarantees that benefits will be paid, even when the organization has the resources. Second, we have no regulatory authority over the entity, and benefits and rates bear no correlation to one another.

We have found that employee leasing firms are the most recent trend in welfare plans claiming an ERISA preemption of State regulation. In these operations, employers enter into agreements which appear to transform the hiring and firing of employees to labor leasing companies. The labor leasing company then leases the employees back to the original employer. Typically, when our department discovers that the leasing arrangement is a subterfuge to primarily provide group insurance, leasing company claims to be a single employer exempt from State regulation due to ERISA.

All of these jurisdictional squabbles, however, ignore the human tragedies that result. Just 2 days ago the Miami Herald told a story of Terry and Craig Mills, a south Florida couple who are living a nightmare. They were members of a failed MEWA. They now have thousands of dollars in medical bills and no operative health insurance. Collection agencies are hounding them. A medical complication that could cost as much as $10,000 is facing Ms. Mills and her baby that are due on June 21.

As public officials, we have to do a better job of serving people like Terry and Craig Mills. First and foremost, the Federal Government should return complete control of health care arrangements, and especially MEWA's, to the individual States. ERISA should be amended to make it clear that it was primarily designed to regulate pensions. If welfare benefits are to fall under it, let it be for unions and large employers. For little firms, more effective regulation means one master, not two.

If Congress were to do that, many of the other suggestions I am addressing now and in my written testimony submitted earlier, would be unnecessary. The real solution is to eliminate duality. Designate one level of government to regulate these health plans, and you eliminate the con artist's ability to rely on deceit, Ponzi schemes, and false hopes of low costs.

My other suggestions are: One, we would like to see Congress increase criminal and civil penalties for ERISA and MEWA violations, and give the States authority to both enforce ERISA and prosecute cases involving fraud and theft; two, the U.S. Department of Labor should be charged by Congress with the job of certifying employee benefit plans so that the legitimate plans are clearly identified as such; three, more resources are needed at the Federal and state level to detect ERISA frauds; four, and we at the State level need to consider stronger laws which I think should require MEWA's to post bonds for the protection of the insureds and limit the fees and commissions an agent or administrator can receive for these so-called nonprofit companies.

I would be delighted, Mr. Chairman, and an appropriate time to respond to any questions that you may have.

Thank you.

Senator NUNN. Thank you, Mr. Gallagher. Before we turn to questions, Senator Roth, do you have any opening statement? And then I will ask Senator Lieberman if he has any opening statement.

## OPENING STATEMENT OF SENATOR ROTH

Senator ROTH. Yes, thank you, Mr. Chairman. Before I make a few short remarks, let me welcome our panel, especially Mr. Gallagher, who has a Wilmington, Delaware background.

I want to congratulate you, Mr. Chairman, for holding these hearings. In 1988, we were spending $540 billion on health care in the United States. That is more than 11 percent of our gross national product. It is more than almost any other country spends on health. Yet we find that we are still having serious problems with coverage and the adequacy of that coverage. And certainly it has become clear that when there is such big money involved that there are some slick operators who will try to find ways to cheat the system.

Mr. Chairman, one of my real concerns is not only this immediate program, but what seems to be characteristic of many Federal programs that are so large, and so big, that they are out of control, and the one who suffers is usually the one who is supposed to benefit from the program. That is why I commend you and your staff for initiating this investigation into this critically important area.

While we don't know the number of fraudulent plans operating in the United States, we do know, as I think Mr. Gallagher and others pointed out, it is the individual, the family, who ultimately suffers, and that cannot be permitted.

Mr. Chairman, I would just like to point out that in line with what the majority is doing, the minority staff is pursuing investigations into two somewhat related areas involving health care. One area is a Medicare secondary payer program where the Federal Government appears to be losing billions of dollars because insurance companies, health care providers, and Medicare intermediaries are not complying with or enforcing the law which makes Medicare a secondary payer on some claims.

Another investigation involves the practice of certain so-called revenue recovery firms who hire themselves out to hospitals for a percentage of the additional bills they generate for so-called lost charges. This too seems to be another approach of getting into the U.S. Treasury.

So I congratulate you and the majority staff, Mr. Chairman, for the efforts to examine the abuses in the health care industry. We look forward to working with you on this matter in the future.

[Senator Roth's prepared statement follows:]

### Prepared Statement of Senator Roth

Health care and its rising cost have become issues of serious concern for all Americans. In 1988, spending on health care in the U.S. reached $540 billion, that's more than 11 precent of the U.S. gross national product. When there is that much money involved, it should come as no surprise that slick operators have developed schemes which prey upon the unsuspecting and leave victims scarred for life. That is why, Mr. Chairman, I commend you and your staff for initiating this investigation into this very important area.

The hearings today are particularly important, because they look at a problem that has been growing for 15 years. The abuses of Multiple Employer Welfare Arrangements are not new. Although we do not know the number of fraudulent plans operating in the United States, we do know that these schemes treat their victims ruthlessly. By offering low premium rates, corrupt operators are able to sell their plans to unsuspecting businesses. Such plans are usually self-funded and rely solely on premiums to cover all of their expenses, including claims. When the claims become too large to pay, the operators simply stop paying and move someplace else to set up another scam.

As I said previously, Mr. Chairman, I applaud your efforts to uncover abuses in our health care system, and you have my full support in this endeavor. As you know, the Minority staff is pursuing investigations into two somewhat related areas involving health care. One area is the Medicare Secondary Payer program where the federal government appears to be losing billions of dollars because insurance companies, health care providers and Medicare intermediaries are not complying with, or enforcing, the law which makes Medicare a secondary payer on some claims. Another involves the practice of certain so-called "revenue recovery" firms who hire themselves out to hospitals for a percentage of the additional bills they generate for so-called "lost charges."

I am pleased that PSI is making the effort to examine abuses in the health care industry. These are problems that we need to pursue, because they have the potential to affect every person in this country.

Senator Nunn. Thank you, Senator Roth. We appreciate your leadership in this area and look forward to working with you in your investigations, and we appreciate your cooperation in this one very much.

Senator Lieberman.

### OPENING STATEMENT OF SENATOR LIEBERMAN

Senator Lieberman. Thank you, Mr. Chairman. I too thank you and congratulate you on convening this hearing, and I congratulate your staff on the characteristically superb work that has been done in preparation for this hearing.

Mr. Chairman, I have a statement which I would ask to be included in the record. Sitting here and listening to the witnesses, reading the material that your staff provided, it really takes me back to my time as Attorney General of the State of Connecticut. This is a classic and unfortunate situation, where there is extraordinary demand for a product or service, the market cannot take care of that demand, and con artists and Ponzi scheme operators come in and take advantage of that situation.

All of us have talked about the health care cost crisis. I can tell you—and I'm sure it is true of most of my colleagues—at every town hall meeting that I go to in Connecticut, the No. 1 source of consumer anger is the cost of health care, and the No. 1 source of anxiety, particularly from the small businessowner, is how in God's name am I going to be able to afford this. Factor in the existence of unscrupulous MEWAs, and you have a serious problem that, as you have very well documented, has dramatically affected consumers and small businesses. The insurance industry is a source of pride in the State of Connecticut, and I might add that today's testimony suggests that there are legitimate insurance companies being victimized by these problems as well.

There is one case that you referred to, Mr. Long, where a health insurance MEWA was established by a separate operator and Travelers, which has an outstanding reputation, was brought in to administer the plan. But the health plan was not funded or guaranteed by Travelers. Travelers was just supposed to process the claims.

Nonetheless, many of the 80 small businesses and thousands of employees who joined the plan were apparently misled by the MEWA operator into believing that the plan was actually insured by Travelers. And the company that was operating the plan did not set aside the required funds for payment of claims. As a result, many of the claims went unpaid, and Travelers, although not obliged to do so, has paid nearly $900,000 worth of claims with its own money.

In these cases, ambiguity in the law seems to invite con artists. It is a classic case where the law has an important role to play. If we leave people to do what they will do on their own, unfortunately, they will take advantage of one other. And the problem here, as the witnesses have so well described, is that the law has not been clear and forceful. And where there is ambiguity, these health insurance con artists will find an opening. It is like a snake slithering through a crevice in the rocks—they will find the point where they can enter, and they have.

I think it is incumbent on us to close those cracks and to make sure that there is clarity and toughness in the enforcement of the law. Mr. Chairman, I think we are really on the cutting edge of something that is critically important to the American people. They pay so much for health care, they cannot afford to pay more to con artists and Ponzi scheme operators, and I hope this Committee will help lead the way to a clarification of the law that will protect the American consumers.

[The prepared statement of Senator Lieberman follows:]

## PREPARED STATEMENT OF SENATOR LIEBERMAN

Mr. Chairman, I want to thank you for holding this hearing on fraud and abuse in employer sponsored health benefit plans. Few issues are of greater concern to consumers than health care. And health insurance today is so exorbitant that our country simply cannot afford the additional costs imposed by health insurance con artists and Ponzi scheme operators.

Over 25 million employed Americans have no health care coverage for themselves or their families, and a total of 37 million Americans have no health insurance at all. For those who do have health insurance, the costs have skyrocketed for them and for their employers. In 1988 alone, the corporate cost of health care benefits rose by almost 19%.

Given the escalating cost of health insurance, especially for individuals or small groups of employees, small businesses trying to provide health care for their workers often turn to "multiple employer welfare arrangements," or "MEWAs." These plans, often set up by trade associations or independent companies, are intended to make insurance coverage more affordable for small companies by pooling their employees into one large plan. Unfortunately, these plans are often underfunded or mismanaged. Honest but incompetent operators can find themselves with inadequate reserves to pay employees' claims and end up in bankruptcy. Worse still, many plans are set up by fraudulent promoters, who siphon off funds that are supposed to be set aside to pay claims and use them instead to line their own pockets. Once these operators have signed up employers and collected premiums, they milk the plan and abscond with the money.

Either way, the employees end up without viable health coverage. Employees lose, small businesses lose, and legitimate insurance companies often lose as well. In one of the examples to be examined in this hearing, a company established a multiple employer health benefits plan that was to be administered by Travelers Insurance Company. The plan was not funded, insured or guaranteed by Travelers; Travelers was merely to administer the plan and process claims under it. Nonetheless, many of the 80 small businesses and thousands of employees who joined the plan were mislead into believing that it was insured by Travelers. Moreover, the company operating the plan did not set aside the required funds for payment of claims, and as a result, many employees' claims went unpaid. Though it was not obliged to do so, Travelers paid nearly $900,000 worth of claims with its own money before cancelling its arrangements with the operators of the plan. As this example shows, companies big and small can be victimized by unscrupulous or inept health plan operators.

Anyone listening to the problems caused by mismanaged or fraudulent health insurance plans might well say to themselves, "There ought to be a law." Well, there is a federal law, the Employee Retirement Income Security Act ("ERISA"), and there is state insurance regulation as well. Unfortunately, many multiple employer health insurance plans fall somewhere in the penumbra where federal regulation under ERISA and state insurance regulation meet.

A 1983 amendment to ERISA was supposed to have subjected most MEWAs to state regulation, but there is still a great deal of confusion. For example, a MEWA that is not fully insured is subject to any state insurance law that is not inconsistent with ERISA, but there is ambiguity and uncertainty as to what provisions are consistent with ERISA. Unprincipled operators of MEWAs do not hesitate to claim immunity from state regulation due to federal preemption, and it can be costly and time consuming for state regulators to get a court ruling on preemption.

The federal regulatory system may have some inadequacies as well. Under federal law, for example, an operator of a MEWA must file an annual report, but it is not required to file its first report until 1 year and 7 months after the benefits plan is established. That's just enough time for a con artist to set up a plan and bleed it dry.

The time has come to clarify the law and give state and federal regulators the tools they need to protect the consumer and put fraudulent health plan operators out of business. I thank you again, Mr. Chairman, for convening this hearing, and I look forward to working with you to solve this problem.

Senator NUNN. Thank you very much. I am going to insert a statement in the record on the Travelers' position. They have submitted a statement and their point of view on this certainly needs to be put on the record in this hearing.[1]

Let me just ask two or three questions to our panel this morning, and then I will defer to my colleagues. Mr. Gallagher suggested that we eliminate duality, get the Federal Government out of this area and make it clear who is supposed to regulate it, that is, the States.

Let me ask, Mr. Long, your comment on that and Ms. Howard's comment on that.

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[1] See Exhibit No. 13 on p. 236.

Mr. JIM LONG. Mr. Chairman, I totally agree with that view, and please don't take this as a harsh comment or criticism of the Congress, but we are finding on the State level that any time the Federal Government gets into the area of insurance, as Ms. Howard's chart so ably demonstrated, it confuses the issue. It was somewhat predictive by Senator Lieberman's comments that when you have a tight market on health insurance, as we are experiencing right now, and the rates are going up, and the affordability and availability problems that we have heard, Senator, that you have these groups, these thieves come into it.

We saw the same thing, Mr. Chairman, on the tight commercial liability market several years ago when the Congress enacted the Risk Retention Act, and all of a sudden we had legitimate risk retention groups and purchasing groups, and then we have some very illegitimate ones coming into the market also. It is the same problem. The States can do an incredibly good job of regulating insurance entities if we can keep those lines of demarcation clean so we know our jurisdiction and have the authority to go after them.

So I second Mr. Gallagher's comments on that and we ought to keep the lines clear.

Senator NUNN. Ms. Howard.

Ms. HOWARD. Yes, thank you. I agree with my colleagues. And as I pointed out, this large national problem of what to do about health insurance is a gigantic issue before us in the 1990's. Short of a national health care program, the States are going to have to design frameworks for dealing with the uninsureds in their States. My colleagues here are leaders in efforts at the National Association of Insurance Commissioners level in looking at frameworks that States can adopt and build on to make sure that the citizens of our States have access to affordable insurance, particularly in the health area.

I don't think we can solve that bigger problem until we can bring everyone in our State on the same playing field. We must get back to community rates instead of individually rated health insurance where sick people have enormous, enormous medical health costs. So to get a level playing field and bring everyone back in the same plan, that is the only way we as States are going to be able to really deal with the millions of Americans who cannot find or pay for health coverage.

Senator NUNN. As I understand what your suggestion is, Mr. Gallagher, and the other witnesses have agreed, is to get the Federal Government out of the regulatory end of it, but I think you are at the same time asking that the Federal Government get more and more involved in the criminal enforcement; is that right?

Mr. GALLAGHER. We would be willing to carry out criminal enforcement and assist the Federal Government in that if in fact we were given the authority, so I included that in my testimony. But basically, if there are—and there are—legitimate ERISA health plans and the Federal Government would say, we will take care of those, and they are named and listed, at that point we don't have to spend 6 months to a year, and sometimes even longer than that, in establishing whether or not they are legitimate plans through a court system.

And so that would get us so far, just knowing what actual plans are in existence and are going to be regulated by the Department of Labor so that we could do the others. And what we have now, of course, is no one is sure whether a plan is or isn't regulated by anyone, and both claim when the Feds come in that it is a state, and the state comes in that it is a Fed, and it really is up to a court's jurisdiction to come to a conclusion, which takes a very long time.

Senator NUNN. Let me ask one other question to the whole panel here. What can employers themselves do? What are the danger signals that employers ought to look to before they go into one of these multiple employer plans, and also, the same question for employees. It is much more difficult, I am sure, for employees to look behind it, but are there any words of advice that any of you have for employers particularly.

Mr. GALLAGHER. Mr. Chairman, I will start this answer. Different States, of course, have different methods. One of the first times that we even realize a plan is being marketed in the State is when in fact we get consumer complaints. Each of our States are heavily involved in the consumer complaint area. That is how we give the best service to our constituents. And we sometimes find out about these marketing of health plans to employers when in fact employees call with problems in getting claims paid. At that point we find that there are programs marketed that we knew nothing about, that have either come in from other States, or in some cases, from out of country. And they come in with the schemes, basically, to give more for less.

Our problem is at that point we have to issue consumer alerts to let consumers, employers know that these are not licensed entities in the State of Florida. At that point we go after and try and find those people who are marketing that plan, many times through insurance agents that believed it was a legal plan. In the State of Florida, one can, as an employer or an employee, call our consumer assistance 800 number and we will tell them whether or not it is an approved plan in Florida. That doesn't always mean whether or not it is a labor union plan or some other nationally recognized ERISA plan.

Senator NUNN. So they could have a legitimate plan that would not be approved in Florida and when they get your 800 number you could say, no, it is not on our list, but it still could be an ERISA approved plan?

Mr. GALLAGHER. Well, at that point we would need to go further. All are supposed to be registered in Florida, so we would tell them they are not a Florida registered MEWA. And we would basically stop at that and hope that they would realize that.

Senator NUNN. But then they have got to go to somebody else to find out whether their plan—they can't call your office and really find out in general whether the plan they are in is legitimate?

Mr. GALLAGHER. Not only they, but do we, Mr. Chairman. In fact, in many cases when we have a name, it is a long time in finding out whether or not it is a legitimate operation.

Senator NUNN. Let's assume some employer or small business got on the phone and called you and they found out that this particular plan they were about to go into was not approved by your office, not legitimate in Florida, but you would have to tell them it might be approved under an ERISA type arrangement by the U.S. Department of Labor, is that right?

Mr. **Gallagher**. Well, what would happen is we would go to find out whether or not they are approved through the Department of Labor, and sometimes by requesting to the Department of Labor whether or not it is a——

Senator **Nunn**. And how long does it take you to find that out?

Mr. **Gallagher**. I couldn't give you an exact amount of time, but the time which it takes, which is in many cases months. What we normally would do, we would go to court to get jurisdiction, and they would go to court saying that we don't have jurisdiction, is what ends up happening.

Senator **Nunn**. You can't call the Department of Labor and find out?

Mr. **Jim Long**. No. sir.

Senator **Nunn**. The Department of Labor doesn't have any——

Mr. **Gallagher**. There are literally thousands of these, Senator, and I am not sure they have any registration of them.

Senator **Nunn**. You are talking about MEWA's now. I am talking about the second category, the ERISA approved.

Mr. **Gallagher**. To my knowledge, there is no registration. What happens is to be an ERISA approved you file an IRS form, which does get forward to Labor, and that is how Labor basically keeps track of them. So there is, to the best of my knowledge, no list so that we could call and get and say is this or is it not.

Senator **Nunn**. So if a small business employer had an unusual advantage and could sit down with you as the Florida Insurance Commissioner and with Ms. Dole as the Labor Commissioner and say to you, now, I am thinking about going into this plan, would you call your departments and tell me if I should or not, you are saying that both of you together can't do that?

Mr. **Gallagher**. Well, I would do this. I would say, these are the seven MEWA entities that are approved in the State of Florida, don't go outside of those, because those are the only ones I have any say so over whatsoever in order to help your insureds get benefits.

Senator **Nunn**. All right. He says to you, these seven charge twice as much as what this company is promising. At that stage you have to say, well——

Mr. **Gallagher**. That is when I, like anybody else, would say be real aware that you may not get any claims paid.

Senator **Nunn**. But you are saying the Labor Commissioner can't tell him either?

Mr. **Gallagher**. Not to the best of my knowledge, Mr. Chairman.

Senator **Nunn**. Mr. Long, do you want to add to that, or Ms. Howard?

Mr. **Long**. What we understand, Senator, is that we would have to seek a determination letter from the Department of Labor. That is the first time we would have a "yes" or "no" on the particular entity you referenced. What we would do is basically the same procedure Commissioner Gallagher would do. We just say if it sounds too good to be true, it is not true. And that is the problem we have.

We, by the way, have taken a pretty hard approach too. We have just recommended to the insurance agents who may be selling these programs, we recommend you have very high limits of errors and omissions, because when the plan is not paying the claims, we are coming after your coverage. And we are doing that currently on several.

Mr. **GALLAGHER**. Senator, just to add to Commissioner Long's testimony, what basically happens is in order for us to find out if a plan is approved by the Department of Labor, we have to come up with all the parameters of the plan, who it is, what it is, and document the plan so that they can look up and see whether or not it is one of theirs that is approved, because, as I say, they have literally thousands of them.

Well, we are caught with maybe only a name, and sometimes it isn't even the right name, they are operating under other names. So it is a major investigatory problem for us as a state to document who the people are that are marketing this plan, if, in fact, it is even a plan. And when we go to try and give a cease and desist order, or any other notice, they go right into court and say that they are trying to stop us, and they don't have the authority.

Senator **NUNN**. And there is no advanced approval required for these plans at all, they can go out and operate for a period of at least, I believe one of your statements said at least 18 months in most cases before anybody does anything about it.

Mr. **GALLAGHER**. Well, it is until they stop paying claims, Mr. Chairman, is usually what happens, because that is the first time we find out about them.

Senator **NUNN**. So it is just an open invitation for anybody who wants to go out and front-end the situation and collect a whole lot of premiums on the promise of later insurance payments and collect a lot of money and then just take off, right?

Mr. **GALLAGHER**. Mr. Chairman, it is sometimes figured that as long as you can collect premiums and pay the small claims and not have a regulator start investigating you, you can continue putting those dollars into your bank account.

Ms. **HOWARD**. Mr. Chairman, to emphasize something that Tom mentioned, I want to go back over and tell you how hard it is for us to get the documentation from these plans. In order to determine whether they are valid ERISA plans, the PWBA asks us to provide them documentation. Understand, these MEWA's do not gladly turn over to us any information. In fact, they resist us in court at every single step. They make it extremely, extremely, excruciating and difficult legally to get the documentation we need, because what they want to do is slow us down. They want to keep it in court. They want to keep it tied up in the civil process.

Senator **NUNN**. Collect premiums and get the money and then——

Ms. **HOWARD**. Time is money. It will eventually go under. We know that generally, because they have no capital and reserves which we require from licensed insurance companies. They don't have the monies put back to pay these large claims when they come. They are paying them out of cash flow, so eventually large claims will take most of these MEWAs down, leaving all of these unpaid bills.

Senator **Nunn**. Do you have any way to get in touch with the employers of your State, other than public service announcements and that kind of thing, to warn them about this? How do you go about telling employers that they should not go into any MEWA that is not approved by your own office?

Mr. **Gallagher**. Mr. Chairman, in a State that has over 400,000 small employers we don't have a method, other than using the media and, as you say, public service announcements. We have issued press releases and public service announcements, especially in areas when we know that these illegal operations are taking place, once in fact we have established that they are, to warn employers not to purchase from them. We also have the ability to let the agents know that these are not approved, but it has not proven to be a very good method.

Ms. **Howard**. Employers are sometimes secretive about having these plans, because understand, they don't have to go through the State-mandated benefits that you have to through a licensed insurance company. So the plans are much cheaper, and that makes them seductively attractive to the employers, because they can then buy what they think is adequate coverage for a fraction of the cost that they can buy it from a licensed insurance company. So they like it until they are left holding the bag.

Senator **Nunn**. Senator Roth.

Senator **Roth**. Thank you, Mr. Chairman. I would like to continue this line of questioning, because as I understand the problem, there really is no regulation at any level, and these operators are free to work in their own environment.

Now, the suggestion has been made that we turn over the regulation to the States. The question I have there is, What assurance would we have that the States would feel compelled to undertake the necessary regulation? I gather that with the thousands of outfits in this business it would be a fairly burdensome, rather expensive operation.

The reason I raise this question is that just a few weeks ago we had hearings in another area, on student loans, and we found that one of the problems there was that schools were supposed to be certified by the State as to whether or not they had an appropriate educational program. But since the State had nothing at risk, nothing was happening.

So my question is are we jumping from the frying pan into the fire? Sure, some States may do a good job, but what assurance would we have that they would take this responsibility seriously, and how expensive would it be?

Mr. **Gallagher**. Well, Senator, let me just speak for Florida. And that is that we have established a method by which we do license and watch over and regulate MEWA's. As a matter of fact, we have a law in Florida that requires that all the employers that belong to a MEWA would in fact be assessed for any shortcomings in that plan so that all the claimants would be paid.

Of course, we then found out in a recent one that we had to close, that was approved by the State, that they had committed a fraud in saying that they had more assets than they actually had, and we also found that 30 percent of the participants were individual employee/employers, one person being both. So now we are set with the problem of assessing individuals in order to pay the claims for the others, which is going to be a problem, and we are now changing our law to straighten out that problem by requiring any entity, like a MEWA, any MEWA entity that would insure individuals would have to have at least 3 months of a premium on reserve to handle that individual.

But we are established and ready to oversee all of the ones, and basically the way we see it is that if in fact the Federal Government says that they may have them but they also must fall under someone watching out for the consumer of these to make sure that the claims are paid. We feel in Florida that we have the ability to do that. We would like the additional ability to go against the ones that don't register with us for both civil and criminal fraud that could be set up by the Federal Government.

Mr. **Jim Long**. Senator, in response to your question, if I might, let me just mention to you, as you will notice in my written testimony, I plan to have a bill introduced in our State general assembly next week when they convene on the 21st of this month which will provide for the delegation to the commissioner the authority to adopt administrative rules to regulate MEWA's and the administrators. The bill will also contain provisions for licensing, the licensing fees, taxes on MEWA contributions, and reimbursement to the State for on-site financial and market conduct examinations and audits of the MEWA's and administrators, essentially, Senator, what we have been doing on insurance companies for years.

We are just going to take jurisdiction in every area we can get it, and we may have to fight with the Federal Department of Labor over it, or with the MEWA's themselves, but we are going to go into every area that we can legitimately.

One of the problems is the lack of action that we see on the Federal level. I have a letter dated April 30 from the Department of Labor to one of my North Carolina residents who has been under a plan since 1982. He basically was complaining to the U.S. Department of Labor about his rates going up from $54 a month in 1982 to $771. And the Department of Labor writes back and says:

> The jurisdiction of the Department of Labor extends to employee benefit plans and employee welfare plans covered by Title I of the Employment Retirement Income Security Act of 1974, ERISA. The Department has not taken any position regarding the status of the plan inquired about under Title I.

And that plan has been in operation for 8 years, Senator. That is the kind of response we are getting. And it goes on, and I would be glad to leave this with you, and basically the Department of Labor is saying they have authority under their regs to exempt MEWA's from State regulations. They haven't taken a position and they don't know what they are going to do yet. That is the problem we are faced with.

Senator **Roth**. Let me ask you this question. Do you have any feel how broad a problem this is? Obviously, even one such operator is one too many, but can you estimate? Is it 5 percent, 25 percent?

Mr. **Gallagher**. Senator, I don't think any of us can. What happens is when in fact we get complaints from consumers that have not been paid on their claims, that is really sometimes the first notice that we know that someone is marketing a plan. That many times can be many months after they have sold quite a few employers for a large amount of premium dollars.

We don't ever know what the premium dollars are because when we finally ever get a court approval to go in and to take over the documents, they have been shredded, both the sales documents on collecting the premium, as well as the claims documents so that we can even find who the claimants are and how much is actually owed.

So, other than to tell you that a month doesn't go by that we don't have some complaints against some of these so-called MEWA or other ERISA programs that we have never heard of and don't know anything about and have to start a program to in fact put a cease and desist on them for marketing in Florida, which takes many, many months, and a lot of court time and dollars.

Senator NUNN. If Senator Roth would yield just for a minute, you are saying really there are an awful lot of folks out there that think they are insured right now that are not insured?

Mr. GALLAGHER. Senator you probably couldn't have said it better. I certainly couldn't have.

Mr. JIM LONG. We estimate, for example, in North Carolina that probably 40 percent of our health care market is under some type of self-insured arrangement, legitimate or illegitimate. We have no way of differentiating on that. We have no jurisdiction over it. And just as you said, Senator, we only know about these when a complaint comes in that my employer went bankrupt, all of a sudden I find out that no health insurance is in place, and the wife is in the hospital, or I have just gone into Duke University to have a heart transplant and they said no.

That is kind of a shock, and that is the ones we are running into. Those are the situations that will force us to act, because we want to act right now, Senator, because we, like you, particularly Commissioner Gallagher, myself, and your two home State commissioners, are elected. I mean, we are very responsive to the people's needs.

And this is not to say that our Texas friends are not. They are also that same way. But we understand the situation and we have to react on an hourly basis. One complaint is one too many. We want to be able to resolve those.

Senator NUNN. Senator Roth, we have a vote up there. I'm going to ask them to check the time, but this is a cloture vote so probably when you get through with your questions we are going to break.

Senator ROTH. Let me just ask one further question now, Mr. Chairman.

Is self-financing a sound approach, or should there be some requirement of insurance? And if so, will that increase the costs so measurably that it will rule out a lot of coverage?

Mr. JIM LONG. It could or it could not, Senator. Let me change the subject slightly and give you an example. We authorize in North Carolina, for example, self-insured workers' compensation plans. It has been in operation for our State for a number of years. In 1985, I took jurisdiction of those plans. Before there had been a simple registry process. You needed a name and address of Sam's Drywall. That's the only thing the State worried about.

Now we regulate them. We require an annual financial statement, a certified financial statement. We require reserving. We make them pay the premiums as if they were paying in a commercial plan. And Senator, we even set up a guarantee fund, a prefunded guarantee fund, which their board got so excited about the process they went back and paid claims 5 years retroactively when they had no obligation to do so and got some of the bankrupt entities and their victims, the employees, caught up.

So it can work. Any of these plans can work, Senator, but there needs to be the oversight mechanism in place to keep the crooks out of the market, to make sure the reserving is done properly, and make sure when the monies flow in, it flows to those benefits, not offshore, as Ms. Howard said.

Senator NUNN. Let me ask one other question. The free market here works to a certain degree, but the difference as I understand it in the whole insurance area—and this is, in effect, one way or the other insurance. You are paying something up front in order to get a promise of something later on if you need it. So in that sense it is insurance as I understand it. Would you agree with that?

Mr. GALLAGHER. That's the way we look at it, Senator.

Mr. JIM LONG. Exactly.

Senator NUNN. And the reason the free market can't be just allowed to go out and work in this situation is there is just too much incentive for fraud to get money now in order to promise something later on, right?

Mr. GALLAGHER. It is a very large temptation for unscrupulous operators, Senator. And in fact, it has been working for them to their advantage.

Senator NUNN. So you have to have regulation at some level, there is no doubt about that philosophically.

Mr. JIM LONG. One key element you missed in that, Mr. Chairman, that is essential in this, health insurance is not a luxury these days. It is an absolute necessity to the average working man and woman and child in this country. You have to have it.

Senator NUNN. And increasingly it is a necessity to the hospitals that are going broke and to the taxpayers at local levels that are going to be required to pick up these. So it is across the board.

Thank all of you for being here. We are going to be having hearings on this, as you well know, not just today but in the future, and we will also be proposing legislation. I know that we will be calling on you for your assistance in that respect, and we thank you very much.

Mr. JIM LONG. We appreciate this, Mr. Chairman. Let me ask you one thing. I noticed the news release on the Travelers, as did Senator Lieberman from his state. Don't prejudge that case. We were probably going after the Travelers on the Cap Staffing plan in our State.

Senator NUNN. You are probably going after Travelers as well as everybody else. So you are saying hold off on making any judgment about that?

Mr. JIM LONG. Yes, sir. If I would not prejudge it in your hearings, we would appreciate it.

Senator NUNN. Good.

Ms. HOWARD. Senator, I would just like to say in closing that everyone loses in this instance. The States lose, the participants lose, the legitimate insurance companies lose. The only people who come out ahead in this are the swindlers and the crooks who take the monies from these workers and spend it for their personal use.

Senator NUNN. Thank you, Ms. Howard. Mr. Long, Mr. Gallagher, we appreciate it very much. And we will come back in about 10 minutes and have the second panel at that stage.

[Brief recess.]

Senator NUNN. The Subcommittee will come back to order.

We may be interrupted from time to time by votes. We have a very important bill on the floor relating to AIDS this morning, so I apologize for the inconvenience to our panel.

Our second panel this morning are people who are on the front lines in terms of the subject we are talking about, because they have experienced the pain and suffering of the fraud and abuse that is the subject of these hearings.

We welcome our second panel of witnesses, Mr. Robert Wagner, a 36-year-old heart attack victim from North Carolina, Mr. Mark Frank from Alabama, whose 3-year-old daughter is battling leukemia, Mr. Fred Smith from South Carolina, who suffers from cirrhosis of the liver. Each of these witnesses has been forced to face these medical emergencies without the benefit of adequate health insurance through no fault of their own.

We are very pleased to have you this morning. We certainly regret the circumstances you find yourselves in. We hope that by sharing this experience with us this morning you can help us sort these problems out and prevent the recurrence of this to so many people out there in America today.

Also joining our panel is Ms. Rebecca Howell, partner in the Stamey-Howell Associates firm, an independent insurance agency in North Carolina, who can testify about her role in marketing an employee welfare benefit plan that eventually became insolvent. Ms. Howell, we appreciate your being here this morning.

I am going to ask each of you if you will stand. We swear in all the witnesses before the subcommittee, from Cabinet officials right on down. That is part of our procedure, so I will ask you to take the oath.

Do you swear the testimony you give will be the truth, the whole truth, and nothing but the truth so help you God?

Mr. WAGNER. I do.

Mr. FRANK. I do.

Mr. SMITH. I do.

Ms. HOWELL. I do.

Senator NUNN. Mr. Smith, I think I will start over here, and then Mr. Frank, and then Mr. Wagner and then Ms. Howell. So we welcome you and we hope you will feel free to tell us what is on your mind this morning.

## TESTIMONY OF FRED L. SMITH, WEST COLUMBIA, SOUTH CAROLINA

Mr. SMITH. Good morning, Mr. Chairman and members of the Subcommittee. My name is Fred L. Smith and I live in West Columbia, SC. They have here I am 53 years young.

Mr. Chairman, my doctors tell me that I have cirrhosis and that I may need a liver transplant in the future, if needed. I cannot have that operation, which would cost approximately $238,000 because I no longer have the health insurance coverage for that procedure. In addition, even though I have new insurance coverage, I must pay for my liver transplant because the cirrhosis was diagnosed when I was covered by insurance issued by Cap Staffing.

In the middle of the summer of 1988 I joined the Associate Group Marketing Company of West Columbia as a sales representative. Associate Group Marketing Company was representing Cap Staffing. Cap Staffing was in the business of employee leasing for companies, doing the company's bookkeeping, and selling to the employee's group life and health insurance plans.

The health insurance plan, I was told, was covered by the Travelers Insurance Co. I bought health coverage from Cap Staffing and paid my monthly premiums consistently. On July 6, 1989, I entered Roper Hospital in Charleston, South Carolina, with a hernia. When I went into the hospital, the hospital contacted Travelers Insurance Co. Travelers verified that I had full coverage at that time. There was not anything else discussed about payment of my bills.

I underwent a hernia operation and 8 inches of my intestines were removed, but during that operation the doctors discovered that my liver was in really bad shape. They told me that someday I may need another operation to replace it. During the last week of July, one of the hospital administrators came into my room and told me that Travelers had contacted the hospital and told them I was no longer covered as of August 1 last year. This nearly gave me a heart attack instead of the liver attack.

I called Cap Staffing in Charlotte, NC, from my hospital bed, and they told me I was still covered and they gave me a phone number who to have the administrator contact. I did so and assumed the hospital called them to verify I was still covered with insurance. Little did I know then what was going to be the outcome.

I got out of the hospital after several weeks stay on August 9, 1989, which was a little over 30 days in the hospital. Today I have over $45,000 in hospital and doctor bills for this operation. The hospital bill alone is over $37,000. Travelers has not paid any of the claims, even though Cap Staffing told me I was covered.

As of this date, Travelers Insurance Co. has not paid my bills and they say that they are not going to pay them because Cap Staffing has gone out of business. The hospital and several doctors are suing me for $37,357.10, but that is just part of the total that I owe. I don't have the money, and that is why I bought the insurance.

The only word that I have got is that Travelers had paid out a large sum of money on other people's claims and Cap Staffing did not reimburse Travelers. Sorry to say, that is their problem, but I had nothing to do with that. I paid my monthly premiums to Cap

Staffing and I was told I was covered by Travelers Insurance Co. Much later I was told that Travelers Insurance Co. really did not issue the health insurance but just administered the Cap Staffing health plan. I don't know how the insurance industry works, but I know, as I said before, that I paid my premiums to Cap and no one is paying my bills and I do need more treatment.

Mr. Chairman, I am a sick man and my liver is in bad shape, but because my liver disease was discovered when I was insured by Cap Staffing, no other insurance company will cover the costs associated with my liver disease because it was a preexisting disease.

Mr. Chairman, I have tremendous medical bills that I cannot pay and no one to help me with this. I will need continued medical treatment for the cirrhosis, and that will be very expensive. I need to have a liver transplant. I have been told that I will not be put on the waiting list without insurance coverage. I don't know exactly what went wrong with Cap Staffing, but I wouldn't wish this on anyone else.

I might add further to this, as I joined Cap Staffing to represent them to other companies, I was told that it was Travelers Insurance Co. that was issuing the health benefits.

Senator NUNN. Who told you that, Mr. Smith?

Mr. SMITH. Just about everyone at the meetings I went to. I was never told, to my knowledge, that Cap Staffing was self-insured.

Senator NUNN. Did anybody from Travelers tell you that?

Mr. SMITH. Not, to my knowledge. I would go to meetings and in these meetings were numerous people holding the meetings, and this is the way it was presented to me. I am very happy to say that I had just—I had not closed out any contracts, because I would hate to have went back to them with this information that I have discovered on my own. And that was the one incentive that I went with Cap Staffing, because see sir, I thought that Travelers was such a reputable company that they would investigated, you know, who was representing them.

Senator NUNN. Right.

Mr. SMITH. And in my heart I thought it was the most wonderful thing had ever happened, and now the disaster.

Senator NUNN. Well, do you have your own business?

Mr. SMITH. No, sir.

Senator NUNN. Who did you work for?

Mr. SMITH. Well, right now the doctors won't let me do too much work, but I have went to selling—I sell for a builder, sell homes.

Senator NUNN. Who was your employer when you got——

Mr. SMITH. Associated Group Marketing.

Senator NUNN. You were out selling homes?

Mr. SMITH. I am now.

Senator NUNN. What were you doing when you were first insured?

Mr. SMITH. I was representing Cap Staffing through Associated Group Marketing Plan.

Senator NUNN. I see. So you were actually out in the field selling this plan?

Mr. SMITH. Right, sir, I was actually in the field within my heart selling this concept that even they were covered by Travelers Insurance.

Senator NUNN. So you, yourself, as the person doing the selling thought that Travelers was backing the plan?

Mr. SMITH. Yes, sir, wholeheartedly.

Senator NUNN. And that was because the people that owned Cap Staffing, the people you dealt with, had led you to believe that?

Mr. SMITH. Definitely.

Senator NUNN. Did you have any contact with Travelers directly?

Mr. SMITH. No, sir.

Senator NUNN. Did you have correspondence from Travelers, or did you have any kind of written——

Mr. SMITH. No, sir, I had no correspondence with them at all. It was all done through Associated Group Marketing, who was with Cap Staffing.

Senator NUNN. Have you been in this type of business for a long time, or was this your first experience in it?

Mr. SMITH. This was my first experience into that type of business, and probably my last.

Senator NUNN. What had you been doing before?

Mr. SMITH. I was in the building business.

Senator NUNN. Building homes?

Mr. SMITH. Yes, sir.

Senator NUNN. Thank you very much, Mr. Smith. We will come back for other questions.

Senator Roth, do you want to ask a question at this juncture?

Senator ROTH. Yes, I would like to ask a question to Mr. Smith. I understand from your testimony this morning that you were actually selling this benefit plan to others?

Mr. SMITH. Yes, sir.

Senator ROTH. Now, did you ever read the booklet that described the plan?

Mr. SMITH. We had just a brochure.

Senator ROTH. This is a Xerox copy, "Employee Benefits for You and Your Family, Cap Staffing, Inc."

Mr. SMITH. This is what I was using here. I had just gone with them and was not doing too good when all of that started happening. I did not close out any contracts.

Senator NUNN. But you feel fortunate that no one else has gotten this from you.

Mr. SMITH. I thank God they did not. See, I had to wait until my insurance license was issued before I could go out and actually sign up contracts, and this happened before my insurance license came.

Senator ROTH. Mr. Smith, I guess the question, as one who was a salesman of this, what had you read to prepare yourself for that particular duty?

The reason I am raising this question—I want to be up front with you—is that this is a copy of their brochure. On the front page they say "The Travelers." Then you look inside on the main sheet and it says "Summary Plan Description and Certificate of Insurance, Insured by the Travelers Insurance Company, Hartford Connecticut."

That is on the summary page, which is probably as far as many buyers got. But then you go further in and in relatively small print it says:

Your health benefits plan, notice to employees, effective March 1, 1989, all benefits becoming due under the health benefits plan are paid directly by Cap Staffing Inc. The Travelers Insurance Co., Hartford, CT, herein referred to as The Travelers, has been appointed by Cap Staffing, Inc., to pay benefits on behalf of Cap Staffing, Inc., in accordance with the terms of the plan and to perform certain other services on behalf of the plan.

So on the front it appears that Travelers is behind it, but if you read the small print, it seems to read otherwise. But I am curious, as a salesman you had not read that?

Mr. SMITH. To my knowledge, I have not read that.

Senator ROTH. Did they give you any training program in preparation?

Mr. SMITH. I went to a couple of the meetings, which this lady here had held one of them.

Senator ROTH. That is all I have. Thank you, Mr. Chairman.

Senator NUNN. Thank you, Senator Roth. Mr. Frank.

## TESTIMONY OF MARK FRANK, ANDALUSIA, AL

Mr. FRANK. Good morning, Mr. Chairman and members of the Subcommittee. My name is Mark Frank. I have been a salesman with Bonds Distributing since February 1988. Bonds Distributing is a lawn mower and chain saw parts distributorship in Charlotte, NC. As a part of my benefits of my employment, Bonds paid for my hospital and medical coverage. I don't recall how much. I paid premiums of $60 to $70 for additional coverage for my family, which was taken out of my paycheck every 2 weeks.

We originally were insured through Cap Staffing, which we thought was being handled by Travelers Insurance Co. The agency that handled this for Bonds was Stamey-Howell Associates of Kannapolis, NC. We received cards, booklets with Travelers' name on it, so I naturally assumed my insurance was Travelers insurance that Cap had bought and Bonds paid for. I didn't receive the health care coverage booklet until approximately 1 month later after I signed up for the coverage. I never had the opportunity to examine the booklet before this. I understand from talking with members of your Subcommittee that Cap Staffing was an employee leasing company. Bonds did not lease their employees from Cap Staffing. I was never employed by Cap Staffing, but Bonds' employees were told by the Bonds' manager that if we were asked who we worked for, we were to say we worked for Cap Staffing for insurance purposes.

In April 1989, my 2½ year old daughter, Susan, started having nose bleeds, so my wife and I took her to the doctor. The doctors were at a loss as to the cause of the nose bleeds, so they conducted tests throughout the months of April and May. On June 7, 1989, they told us that Susan had acute myeloblastic leukemia, or AML. We were told that this is a rapidly fatal form of leukemia and that Susan's chances for short-term survival was only 30 to 50 percent.

Between June and October Susan received treatment at the USA Medical Center and IV Services in Mobile, AL. During this time she received six chemotherapy treatments. As we received the bills for Susan's treatment, the hospital filed our claims with the insurance company. Sometime during the week of July 24 we were notified by my supervisor, Neil Campbell, that Bonds had to change insurance companies because Cap Staffing had not remitted the premiums to Travelers and that Travelers was going to terminate the coverage effective July 31, 1989.

Before this I thought my insurance was through Travelers Insurance. Neil Campbell of Bonds Distributing told me that they were looking at several companies and that Susan's case was priority No. 1 with Bonds, that they were not going to insure with anyone that would not agree to assume her care. She had already been diagnosed as having leukemia.

Universal Staffing Associates, Inc., and National Benefit Consultant, Inc. [USA and NBC], assumed the coverage effective August 1, 1989, with knowledge of Susan's diagnosis. Susan was in the hospital in Mobile at this time on August 1, 1989. Between August 1989 and October 1989 she was scheduled to return to Mobile for maintenance chemotherapy to maintain her remission. She was referred to the University of Minnesota Hospital and Clinic in Minneapolis on October 21, 1989.

In June and July 1989 they began to search for a suitable bone marrow donor. Ten donors were identified, and the hospital started the appropriate tests on them. Around this time, in August 1989, the hospital found out that Travelers had stopped processing and paying any claims. Minnesota Hospital immediately stopped any testing on the donors and would not continue with the appropriate tests on Susan to prepare her for her bone marrow transplant.

This testing stopped for about 2 weeks while waiting for confirmation of insurance coverage from Universal. Some of the doctors became involved and told the university that my daughters case was an emergency and that she soon would die without medical attention. The university said that they would not continue any additional testing until I sent them a check for approximately $8,963 to cover the cost of the tests that they had stopped.

Through local fund raisers we collected $8,963 to cover the cost. Unfortunately, all of this took time, something that my daughter had very little of. After I mailed my check, Universal confirmed the insurance coverage. On December 24, 1989, we were finally able to take Susan home from Minnesota.

Universal Staffing has never paid any of Susan's medical bills and it doesn't appear that they ever will. I was told by Universal that I would be covered. Universal tried to return the premium payments Bonds paid for the month of December, saying that they were not covering Bonds or me in December. I owe the University of Minnesota and Clinic more than $128,000 plus doctor fees, Mobile IV Services for more than $21,000, and doctors probably over $100,000, and an additional $15,000 had accrued from the Mobile treatment prior to cancellation by Cap Staffing and Travelers on July 31, 1989, which has never been paid by Cap Staffing or Travelers, although these services were incurred prior to Cap Staffing or Travelers self-imposed the cutoff date.

Since then, I have had creditors send notices in the mail threatening to garnish my wages and we have tried to obtain insurance, and was only able to do so with Blue Cross-Blue Shield after Susan was discharged. Susan just had her third birthday, her prognosis is very positive. I am facing bankruptcy and financial ruin if the medical bills are not paid. The insurance company has ignored the bills and will not answer requests for payment. The University of Minnesota is calling on me for payment. I cannot pay these catastrophic bills.

Senator **Nunn**. Thank you, Mr. Frank. You mentioned here that Blue Cross-Blue Shield has insured you. You do have coverage now?

Mr. **Frank**. At this time I do, through Blue Cross-Blue Shield.

Senator **Nunn**. Is Susan covered now by them?

Mr. **Frank**. Yes, she is.

Senator **Nunn**. For her existing condition?

Mr. **Frank**. She is.

Senator **Nunn**. How were you able to get that coverage?

Mr. **Frank**. The problems that we had when the insurance was going to be terminated through Universal Staffing was in the latter part of November 1989 while Susan was in the hospital, undergoing her bone marrow transplant. We were notified then that Bonds was going to have to change insurance. Blue Cross-Blue Shield would pick Susan up with her condition as is after she was discharged only. Therefore, Bonds had to go back and ask for a continuation through the month of December, which we did get. Bonds did make a check payable to Universal Staffing and they covered us through the month of December until December 31. December 24, Christmas Eve, we were discharged from University Hospital.

Senator **Nunn**. So Blue Cross-Blue Shield didn't go back and pick up the previous bills?

Mr. **Frank**. No, sir.

Senator **Nunn**. How big a company is Bonds?

Mr. **Frank**. It employs approximately 24 or 25 people.

Senator **Nunn**. How long have you been working for them?

Mr. **Frank**. February made 2 years. February 1988 is when I went to work there.

Senator **Nunn**. Approximately what is your salary range, approximately what income do you have?

Mr. **Frank**. It is $25,000 to $30,000 a year.

Senator **Nunn**. Does your wife work?

Mr. **Frank**. Yes, she does.

Senator **Nunn**. So it is just about impossible for you to pay these bills?

Mr. **Frank**. That's correct.

Senator **Nunn**. And I think you said clearly you thought Travelers was backing this policy.

Mr. **Frank**. That's correct.

Senator **Nunn**. Why did you think that?

Mr. **Frank**. The Travelers card that I was issued with my name on it with a policy number, the handbook that we received approximately 4 weeks after signing the coverage was the Travelers handbook, the same one here.

Senator **Nunn**. Is that the one right here?

Mr. **Frank**. That's correct, that's it.

Senator **Nunn**. It has "Travelers" on the bottom of it?

Mr. **Frank**. Yes, sir, the identical book.

Senator **Nunn**. Travelers on the back of it?

Mr. **Frank**. That's correct.

Senator NUNN. Then on the inside of it, it says "Under the group and health insurance plan Cap Staffing, Inc., called the employer, insured by the Travelers Insurance Company, Hartford, Connecticut."

Mr. FRANK. Correct.

Senator NUNN. And then it goes on to say, "The Travelers Insurance Company has issued group policy number G and GA118203 covering certain employees of the employer."

Mr. FRANK. Right.

Senator NUNN. I understand that that is actually life insurance and not health insurance, but you would never know it by reading this, would you?

Mr. FRANK. No, sir.

Senator NUNN. Senator Roth.

Senator Roth. I have no further questions.

Mr. SMITH. Mr. Chairman, I have here my insurance card that I gave to the hospital, if you would like to see it.

Senator NUNN. Let me get the clerk to bring it up.

Mr. SMITH. It might be of help.

Senator NUNN. Thank you, Mr. Smith.

Senator ROTH. While you are waiting for the card, could I ask you one question, Mr. Frank. Did other employees have the same feeling, that they were covered by Travelers? Was that the general understanding in the organization?

Mr. FRANK. That's correct. All the employees were under the assumption that we were covered by Travelers Insurance, and the card--I have an identical card as Chairman Nunn has, with my name on it.

Senator ROTH. Did management ever indicate that to you?

Mr. FRANK. When we were told, we were told that we were insured by Travelers through Cap Staffing, and that is as far as it got. And I didn't ask any questions. I had no reason at that time to ask any further questions, other than I had heard that Travelers was a good insurance company.

Senator ROTH. Well, I have to say, Mr. Chairman, that if I received that card I fear I would have exactly the same conclusion.

Senator NUNN. I think 98 percent of the people would. It says, "The Travelers Insurance Company, payer number," and it gives the number, "Cap Staffing, Inc." But the big print is, "The Travelers Insurance Company."

And on the back it has "The Travelers," in big print, and then it says, "This group health benefit plan is administered by the Travelers Insurance Company."

I guess one could make a distinction between administered and insured, but I don't think most people in this country would.

Senator ROTH. Mr. Chairman, does it show who issued that card? Was that card issued by Travelers, itself? You wouldn't know that, would you, Mr. Frank?

Mr. FRANK. No sir, I would not.

Senator NUNN. It is hard to tell.

Senator ROTH. But just looking at it, it certainly does give the perception or impression that it was issued by The Travelers.

Ms. **Howell**. Mr. Chairman, if I might answer that question. I was in the office when cards were brought in and they were brought in in boxes that were stamped "Travelers" also.

Senator **Roth**. Would you pull the microphone a little closer. I couldn't hear you.

Ms. **Howell**. I was in the office when those cards were delivered and they were in boxes that had Travelers' logo on them also.

Senator **Roth**. They were in boxes from the Travelers Insurance Co., so that as far as you could tell they were printed by Travelers and sent to the company for distribution?

Ms. **Howell**. Yes.

Senator **Nunn**. Thank you, Mr. Frank.

Mr. Wagner, we will go ahead to you, and then we will hear from Ms. Howell. I will make a copy of each one of these, if we could, for the file, and they will be listed as exhibits in the record, and numbered sequentially, without objection.[1]

## TESTIMONY OF ROBERT L. WAGNER, WHITEVILLE, NC

Mr. **Wagner**. Good morning, Mr. Chairman and members of the Subcommittee. I am pleased to be here this morning to testify regarding my experiences as a victim in a fraudulent group health plan sponsored by Cap Staffing, a labor leasing company.

My name is Robert Wagner, and I am a 36-year-old single parent of two. I live in Whiteville, NC, and I have worked for 16 years with BRT Holding, the parent company of Homeway Furniture as a warehouse man and truck driver. In my job with Homeway I have had health benefit plans which until now have covered myself and my family. My trouble began in 1989 when Homeway turned to Cap Staffing for affordable coverage. To my knowledge, Cap Staffing had an arrangement with Travelers Insurance Co. to provide health care coverage for 45 to 50 employees of Homeway.

From what I was told by Debbie Bowers, a BRT Holding employee who handled the insurance dealings for the employees, I understood that Cap Staffing was an organization that we sent our monthly premiums to so that we would then have Travelers Insurance coverage.

In June 1989, I experienced an event that was not only a serious threat to my life but has since become a serious threat to my way of life. On June 26, 1989, at the age of 35, I had a heart attack in my home. I was taken to a local hospital, the Columbus County Hospital, and was later flown by helicopter to Duke University Medical Center because of the seriousness of my condition. I spent 7 days hospitalized and another 17 days out of work.

For nearly 4 months after I was released from the hospital my medication alone averaged between $300 and $400 each month. These bills alone, with doctor bills, hospital bills, and followup treatments were submitted as claims to my insurance company. These bills totaled more than $12,000.

My purpose in being here before you is to bring to your attention that although I was faithfully paying monthly premiums, in reality I, along with the other Homeway employees, was not insured through Cap Staffing, Travelers Insurance, or anyone at all. Since working with your subcommittee investigators, I have come to understand that Travelers was providing only administrative services to Cap Staffing. There was no agreement by Travelers to provide health coverage to Homeway employees.

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[1] See Exhibit No. 1 on p. 185.

Although neither I nor my company was told so at the time, Cap Staffing was actually responsible for providing the insurance coverage and failed to do so. Because of this game, my children and I no longer have any insurance coverage. To date none of my claims have been paid by Cap Staffing or Travelers. Perhaps these figures do not seem like much in comparison with those in other stories you might hear today, but for me they are overwhelming. My current take-home pay is $211 a week, or a little more than $10,000 a year. I have all the monthly bills the average person pays, including rent, utility bills and the like. I also have my children to care for, which in my current financial situation has become a real concern.

My biggest concern is that because of my existing heart condition I cannot get insurance for my children or myself. The companies I have talked to either flatly deny me, or the rates are much more than a single father can afford on a salary like mine. Until now I have never in my life been in debt to any degree that matters, but today because of some ugly scheme that has taken root with my heart condition, I am facing bills of over $12,000. I don't know if this has happened to me because of someone else's greed, because the regulations that govern these insurance plans aren't tight enough, or both.

Mr. Chairman, what I do know is that I have worked hard. I paid my premiums, and today I must pay thousands of dollars in bills that I am not responsible for. It is like someone stealing $12,000 from you. Imagine that when $10,000 is all that you earned in a year.

I must say that I have been lucky in the sense that my children haven't been sick or hurt, and for the most part my doctors, those at Columbus County Hospital and Duke University, have been understanding and willing to work with me in paying my bills. Sometimes I do get harassing notices, but thus far I have not been forced into repayment beyond what I can handle. I have to wonder how long their patience will last.

Before I close, I would like you to know that I was hesitant to come before you to tell my story, but I see from the others here that I am not the only person who has been a victim of insurance fraud. Within my company alone there are several other families facing problems similar to mine. I am sure that there are others that face situations far worse than mine. That is why I am here to help. I know this kind of abuse can be prevented, and now we need your help. Enough people have been hurt.

Mr. Chairman, thank you, and I am happy to answer any questions that you or other members of the Subcommittee might have.

Senator **Nunn**. Mr. Wagner, may I ask you a question. We appreciate you being here very much.

Who did you think was insuring you?

Mr. **Wagner**. The Travelers Insurance Co.

Senator **Nunn**. Why did you think that?

Mr. **Wagner**. I received the same information these folks did, this book and things, sir, the exact same thing, which, through Cap Staffing and with Travelers name and everything on it, and reading on the inside page like you showed before, I thought I was insured by Travelers Insurance Co.

Senator **Nunn**. Who did you think Cap Staffing was?

Mr. **Wagner**. Well, to best explain it, a middle man in between that took care of getting the premiums from my company and they would give them to the insurance company. In other words, they were just kind of a middle man.

Senator **Nunn**. You thought they were sort of the conduit to feed the premiums to Travelers?

Mr. **Wagner**. Right. Yes, sir, this was my understanding.

Senator **Nunn**. Mr. Frank, did you think the same thing?

Mr. **Frank**. Yes, I did.

Senator **Nunn**. I believe one of you said in your statement that you were told that you actually worked for Cap Staffing, is that right?

Mr. **Frank**. For insurance purposes. When we were administering the card to the hospital and they asked our employer, we were to tell them Cap Staffing. And I was told then that was——

Senator **Nunn**. So they were saying for insurance purposes you were working for Cap Staffing, not your company?

Mr. **Frank**. That's correct.

Senator **Nunn**. But you didn't have any employer, or anyone at Cap Staffing who told you when to come to work, did they?

Mr. **Frank**. No, they did not.

Senator **Nunn**. They didn't pay your check, did they?

Mr. **Frank**. No, they did not.

Senator **Nunn**. They didn't supervise your job, did they?

Mr. **Frank**. They did not.

Senator **Nunn**. So it was only a guise for insurance purposes?

Mr. **Frank**. Correct.

Senator **Nunn**. Mr. Smith, did you have the same experience?

Mr. **Smith**. The same thing.

Senator **Nunn**. Mr. Wagner, did you have that same experience?

Mr. **Wagner**. Sir, I'm sorry.

Senator **Nunn**. Did you have that same experience? Were you told that you worked for Cap Staffing?

Mr. **Wagner**. That I worked for them?

Senator **Nunn**. They didn't tell you that then?

Mr. **Wagner**. No, sir.

Senator **Nunn**. Senator Roth.

Senator **Roth**. I have no questions, Mr. Chairman.

Senator **Nunn**. Ms. Howell.

## TESTIMONY OF REBECCA MANN HOWELL, STAMEY-HOWELL INSURANCE & INVESTMENTS

Ms. **Howell**. Good morning, Mr. Chairman and members of the Subcommittee. I am an insurance agent in Kannapolis, NC, a small town which is located about 25 miles from Charlotte. I work with Rick Stamey, who is also an insurance agent. Our agency is called

Stamey-Howell Associates. Our clients are primarily individuals, families, and small businesses.

I have been asked here to tell you about the group health insurance plan of Cap Staffing as we understood it. Cap Staffing was a Charlotte company which began the employee leasing business in 1988. Rick Stamey and I and many other agents became involved in selling Cap Staffing's employee leasing service and employee benefits package, which included a group health benefits plan.

Under the Cap Staffing Program, the employees of our client would become employees of Cap Staffing. The employees would then be leased back to the employer. Cap would handle the clients payroll and other personnel administration services, and the employees would become eligible for Cap Staffing's employee benefit package.

From the very beginning of Rick Stamey's and my involvement with Cap Staffing we were led to believe and we did believe that Cap Staffing's employee benefits plan was a group insurance policy issued by the Travelers Insurance Co.

Senator NUNN. How long were you in insurance business?

Ms. HOWELL. Since 1984.

Senator NUNN. And how about Mr. Stamey?

Ms. HOWELL. Since about 1980.

Senator NUNN. And you both are pretty familiar with insurance, that is your business?

Ms. HOWELL. Our experience in group insurance was limited. I have to say that.

Senator NUNN. What kind of insurance had you been in, primarily?

Ms. HOWELL. Primarily life insurance, and also P&C.

Senator NUNN. But you are licensed in insurance?

Ms. HOWELL. Yes.

Senator NUNN. And you would normally be pretty sophisticated in terms of knowing what was going on in insurance?

Ms. HOWELL. We thought we were.

Senator NUNN. Certainly more so than the average person.

Ms. HOWELL. I would like to think so, yes.

Senator NUNN. Go ahead.

Ms. HOWELL. Only after The Travelers terminated the plan in late July 1989 did we learn that we and our clients were the victims of an apparent fraud, that Cap's health plan was not a group insurance policy. Not until after Cap Staffing went out of business did we learn that most of the money paid by our clients as group insurance premiums had apparently been diverted, leaving thousands of dollars of medical claims unpaid.

Cap Staffing's president was Bob Long. We first heard of Mr. Long from Darren Tietsort, a sales manager of Kentucky Central Insurance Co. Mr. Tietsort called on us to discuss his company's insurance and investment products. After discussing Kentucky Central's products, Mr. Tietsort told us about a company named Cap Leasing located in Charlotte. Mr. Tietsort told us that Cap Leasing was involved in vehicle and equipment leasing. He also told us that he and some of his family and friends had invested substantial amounts with Cap Leasing. He spoke very highly of Cap Leasing and Bob Long. Rick Stamey and I thought that Cap Leasing sounded interesting, so we arranged a meeting with Bob Long. This was in the summer of 1988.

At that meeting Mr. Long discussed Cap Leasing some, but he seemed more excited about Cap Staffing, a new employee leasing company which he said he was starting. He explained to us the basic concept and advantages of employee leasing. He indicated that for the prior 8 or 9 months he had been working hard on putting together this new company. He indicated that he had already spent substantial amounts in attorney fees to make sure that Cap Staffing was properly and legally set up.

Mr. Long gave us a list of his business and personal references and invited us to attend a meeting which he had scheduled for August 31, 1988, to introduce this new company. The concept of employee leasing sounded like something which might be interesting and attractive for some of our clients. Prior to the August 31 meeting, Rick Stamey contacted a number of the references Bob Long had given us and all the responses were positive. Also, some close friends of mine went to church with Mr. Long. They spoke favorably of him and they indicated that their minister, who is very respected in the Charlotte area, had even praised Mr. Long from the pulpit.

After hearing these references, Rick Stamey and I decided to attend the August 31 meeting to hear more about Cap Staffing. There were approximately 200 people there. The meeting lasted the entire morning, and there were several speakers who covered various aspects of Cap Staffing. One of those speakers was Ron Harris, who was introduced as a former CEO of the Travelers. Mr. Harris spoke on the group health insurance benefits which would be offered to employees of companies enrolling in the Cap Staffing employee leasing program. Those attending the meeting were furnished with brochures summarizing the plan. This is the brochure that I am talking about, but this is a copy. The ones they gave us that day were in red.

Senator NUNN. We will make that part of the record and give it an appropriate number, without objection.[1]

Ms. HOWELL. Those brochures bore the Travelers name and logo and gave every indication that the plan was a Travelers group insurance policy. One page of the brochure even referred to the plan as "The Travelers Plan," and "The Travelers Policy," and stated that the benefits were governed by the insurance contract. No where in that brochure was there anything to indicate that the plan was anything other than a group insurance policy.

During a break after Ron Harris' presentation, Rick Stamey spoke with Mr. Harris about the group insurance plan. In the course of that conversation, Mr. Harris assured Rick that he had a good track record and a very good working relationship with the Travelers. Other speakers at that meeting were two attorneys of Cap Staffing who discussed certain legal aspects of employee leasing, a businessman who stated that he was the first company to put his employees on the Cap Staffing employee leasing program and was pleased with the positive results. And Joy Coble, the president of another employee leasing company which had several years of expertise and would be handling all the payroll and personnel administration functions for Cap Staffing.

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[1] Exhibit No. 3 has been retained in the Subcommittee files.

Since Ms. Coble would be playing a key role in the Cap Staffing overall program, Rick Stamey and I visited Ms. Coble at her office and found her and her staff to be very professional and capable. We learned that she had an impressive list of clients spread over several States.

She also told us that she was going to enroll her employees in the Cap Staffing health insurance program with The Travelers. All of this combined made Rick Stamey and I very interested in pursuing the Cap Staffing program further. The employee leasing concept sounded like a viable answer for some of our clients' problems, and we were comfortable with the fact that the group insurance would be with The Travelers, a well known and highly respected national company.

Therefore, we decided to share information about Cap Staffing with some of our business clients to see if they would be interested. We made appointments to see four of them in the same day, and Ron Harris went with us and made the presentation to all four of those clients. During each presentation Mr. Harris first discussed the employee leasing concept, then presented the benefits available to the employees, including the group insurance plan.

He used the same brochure that was passed out in the August 31 meeting and referred to the plan as insurance with The Travelers. Not once in any of those presentations did Mr. Harris give any indication that the plan was not fully insured by The Travelers. A week or so later I took Mr. Harris with me on a call that I made with another client. In that case, I made the presentation and Mr. Harris observed. I made the group insurance presentation much the way Mr. Harris had done in the four prior ones, indicating that the plan was insured by The Travelers, as I believed it was.

After the presentation, Mr. Harris indicated that I had covered all the important points and not left anything out. Bob Long and Ron Harris then began conducting recruiting and training sessions for agents who might be interested in selling Cap Staffing services. Rick Stamey and I, between the two of us, attended a number of those sessions. Ron Harris always gave the presentation of the health benefits plan, each time using The Travelers brochure and never giving any indication that the plan was anything other than a Travelers group insurance policy.

In the course of our sales efforts, Rick and I found a number of employers who wanted to enroll in Cap Staffing's program. In presenting the program, we always presented the medical plan as being insured by The Travelers, as we believed it was. We even enrolled our own agency in the plan, which we certainly wouldn't have done had we known it was not insured by The Travelers.

In early January, at Bob Long's request, Rick and I began conducting the agent recruiting and training classes. These classes were held on a regular basis until July. We always presented the health benefits plan as being insured by The Travelers. Bob Long and Ron Harris observed some of our presentations and the local account manager of The Travelers Employee Benefits Department even attended once. Yet never did they say anything to contradict everyone's clear impression that the plan was a Travelers group insurance policy.

Furthermore, The Travelers name and logo was on the sales brochure, the enrollment cards, the employee ID cards—this is an enrollment card, I'm sorry—the ID card, the claim form, and other materials furnished for us in the use of the sale, enrollment, and administration of the plan. When needed, coverage verification was made by phone through The Travelers. The claims were paid by The Travelers on their company checks. The title page of the benefits booklet given to the employees was entitled "Summary Plan Description and Certificate of Insurance Under the Group Life and Health Insurance Plan for Employees of Cap Staffing, Insured by The Travelers Insurance Company." It even refers to a specific group policy number.

Until Cap Staffing folded, the Cap Staffing health benefits plan always was held out to us as a typical group insurance policy issued by The Travelers. Reinforcing that impression was the lack of any contrary indication from The Travelers. Rick and I were with The Travelers' aforementioned account manager in a number of meetings during which the Cap Staffing plan was discussed, and I personally was in touch with the claims office frequently on claims matters, yet not once prior to late July 1989 did The Travelers account manager or anyone else from Travelers ever indicate to us that Travelers was providing only administrative services or that the plan was not insured by The Travelers.

Senator NUNN. So, Ms. Howell, you were with Travelers direct employees on a number of occasions?

Ms. HOWELL. One of them.

Senator NUNN. One of them. What was his name?

Ms. HOWELL. Harold Pyles.

Senator NUNN. What was his position with Travelers?

Ms. HOWELL. He was the account manager, sales and business development, employee benefits department.

Senator NUNN. Where did he live?

Ms. HOWELL. To my knowledge, Charlotte.

Senator NUNN. And he never mentioned to you that this was strictly an administrative services contract with Travelers?

Ms. HOWELL. No, sir.

Senator NUNN. Ms. Howell, if in the initial presentation of the Cap Staffing health plan it had been stated that Travelers was providing administrative services only to the plan, would that have made a difference to you in evaluating the plan?

Ms. HOWELL. Sure. The fact that a company with Travelers' reputation had sort of put their stamp of approval on the plan, that had a lot of influence on our decision to represent them.

Senator NUNN. I understand that a number of companies that signed up with Cap Staffing ended up signing up only as administrative services clients rather than full employee leasing clients; is that right?

Ms. HOWELL. That's true.

Senator NUNN. Could you tell us the difference there?

Ms. HOWELL. Cap Staffing offered three contracts. One was a full service contract, which was the full lease. The second was a contract under which they only provided administrative and personnel services. The third was a payroll only contract. All contracts for enrollment had to be approved by Cap Staffing.

Senator **Nunn**. Could you give us a rough percentage of the clients signed up by your agency that were for administrative services as opposed to full services?

Ms. **Howell**. Probably about 60 percent were only administrative services and 40 percent were fully leased.

Senator **Nunn**. Did you understand why under this arrangement the company employees were listed as Cap Staffing employees?

Ms. **Howell**. We were told that there had to be a contract between Cap Staffing and that employer that provided for some type of personnel services, and that that in fact showed a coemployer relationship and that entitled them to be on the program.

Senator **Nunn**. Before you got into this, were you familiar with what a self-insured group health benefit plan was?

Ms. **Howell**. As I stated earlier, my experience in group insurance was fairly limited before I got involved with Cap Staffing, but I do know that had I ever heard the term "self-insured, ASO," or "TPA," I did not know what those terms meant, and I would have asked.

Senator **Nunn**. You don't think you heard those terms?

Ms. **Howell**. No, sir.

Senator **Nunn**. What does TPA mean?

Ms. **Howell**. Now I know it means third party administrator.

Senator **Nunn**. Tell me about the other terms, what they mean.

Ms. **Howell**. ASO means administrative service only.

Senator **Nunn**. And the first initial.

Ms. **Howell**. Self-insured means the plan is a pool.

Senator **Nunn**. Meaning there is no big company standing behind it?

Ms. **Howell**. Exactly.

Senator **Nunn**. And you say you were not familiar with those terms?

Ms. **Howell**. No, sir.

Senator **Nunn**. And you are saying that if you had heard those terms you believe you would have asked further questions about them?

Ms. **Howell**. Yes, that would have been a red flag, because that would have been something that I was not familiar with and I would have asked for an explanation.

Senator **Nunn**. You are a pretty inquisitive person?

Ms. **Howell**. Yes, sir.

Senator **Nunn**. More so now?

Ms. **Howell**. Definitely.

Senator **Nunn**. Were you ever asked to become a licensed insurance agent with Travelers?

Ms. **Howell**. Yes, I was.

Senator **Nunn**. Who asked you?

Ms. **Howell**. Ron Harris.

Senator **Nunn**. Did he say he had been with Travelers?

Ms. **Howell**. Yes, he did.

Senator **Nunn**. Do you know whether that was true or not?

Ms. **Howell**. For a fact, no, sir.

Senator **Nunn**. You believed it though?

Ms. HOWELL. I believed it, yes.

Senator NUNN. Well, did he have authority to hire someone for Travelers? He wasn't working for Travelers then, was he?

Ms. HOWELL. No, sir. When he asked me to become licensed with Travelers, he called Harold Pyles and got Harold on the phone, and I talked with Mr. Pyles and gave him the information so that I could be licensed with Travelers.

Senator NUNN. So you were talking directly to a Travelers agent?

Ms. HOWELL. Yes.

Senator NUNN. Did he ask you to become an agent himself, Mr. Pyles?

Ms. HOWELL. I can't remember whether he specifically asked me or not.

Senator NUNN. He was just accommodating the request.

Did you become affiliated with Travelers?

Ms. HOWELL. I became a licensed rep, yes.

Senator NUNN. For Travelers?

Ms. HOWELL. Yes.

Senator NUNN. During this same time frame?

Ms. HOWELL. Yes.

Senator NUNN. While you were out selling this group health plan, you were working for Travelers yourself?

Ms. HOWELL. I never held myself out to be a representative of Travelers. I held myself out to be a Cap Staffing representative.

Senator NUNN. But indeed you were licensed to sell insurance policies directly for Travelers during this period?

Ms. HOWELL. Legally I suppose I was. I did not.

Senator NUNN. You did not do any of that?

Ms. HOWELL. No.

Senator NUNN. Did you ever sell any policies for Travelers?

Ms. HOWELL. No, sir.

Senator NUNN. You felt you were legally entitled to but you did not?

Ms. HOWELL. I never questioned whether I was legally entitled to. I never had a reason to.

Senator NUNN. Well, did you get a certificate saying you were—what do you get in order to be able to sell?

Ms. HOWELL. I got a status report from the North Carolina Insurance Commissioner's Office that shows that I am licensed with Travelers.

Senator NUNN. And you still are?

Ms. HOWELL. To my knowledge, yes.

Senator NUNN. Did you represent a lot of different companies in your agency?

Ms. HOWELL. Yes, sir.

Senator NUNN. So you were writing policies for a lot of companies, or selling policies?

Ms. HOWELL. Yes, sir.

Senator NUNN. A lot of big companies?

Ms. HOWELL. Yes, sir.

Senator NUNN. Did you have any other client like Cap Staffing?

Ms. HOWELL. No, sir.

Senator NUNN. Was this sort of a unique arrangement?

Ms. HOWELL. Yes, sir.

Senator NUNN. Senator Roth.

Senator ROTH. Now, you said you had contact with one individual who worked for Travelers; is that correct?

Ms. HOWELL. Actually, there were several. I had contact with Mr. Pyles, but then I also worked with the claims representatives when there was some reason that an employee could not get his coverage verified or there was a question on a claim. So I actually worked with several people at Travelers.

Senator ROTH. And none of them ever indicated to you that Travelers was only responsible administratively?

Ms. HOWELL. No, sir.

Senator ROTH. Now, is it possible that they were in the same position that you were, that they did not know better? For example, you were licensed to sell insurance for Travelers but you weren't actually aware of the fact of the limited involvement.

Could that have been true of these others?

Ms. HOWELL. I don't know that I am qualified to answer that. I suppose it could be. I don't know.

Senator ROTH. Let me ask you another question. No one indicated to you that Travelers' involvement was only administrative, but I would think that a program was valid if it was being administered by the Travelers, even though The Travelers' activity was limited.

Wouldn't the average person tend to assume that a major responsible insurance company that was administering a program would look into the soundness of the plan?

Ms. HOWELL. Yes, sir. I think the average employee would, certainly.

Senator ROTH. So in a sense I am not sure whether that makes such a significant difference or not. In other words, if they put that they were administratively handling the plan, I think that would have given me as an employee some assurance it was a good program.

Ms. HOWELL. Exactly.

Senator ROTH. Now, one further question I have, Ms. Howell, you mentioned that the literature and the cards would seem to infer that Travelers was something more than an administrative agency. You don't know for certain where those cards came from, whether they came from Travelers, or whether they came from Cap Staffing?

Ms. HOWELL. I have no exact knowledge of that. I know that things came into the office in Charlotte and there were deliveries made to our office that came in boxes marked with Travelers' logo.

Senator ROTH. I'm sorry, they were what?

Ms. HOWELL. There were deliveries made to the Charlotte office of Cap Staffing, and there were deliveries made to our office, Stamey-Howell Associates in Kannapolis, that were in boxes that also carried Travelers' logo. But as to where they came from, you know, I'm——

Senator ROTH. But the boxes themselves, it appeared that they came from Travelers?

Ms. HOWELL. Yes.

Senator ROTH. Do you know, Ms. Howell, of any actions taken by Cap Staffing to ensure that those covered under its health plan would continue to have health coverage once they received notification from Travelers that its contract would be canceled as of August 1, 1989?

Ms. HOWELL. No, sir, I do not.

Senator ROTH. You have no knowledge.

Thank you, Ms. Howell.

Mr. SMITH. Mr. Roth, may I add something to this?

Senator ROTH. Yes, please do.

Mr. SMITH. Even after I came out of the hospital I felt confident that Travelers would pay my bills up to August 1. And they sent me claim forms that were the original on Travelers original claim forms with the little red umbrella, and I had no doubt in my mind that they would not be paid, because that was an official Travelers claim form.

Senator ROTH. You had no doubt but that they would be paid?

Mr. SMITH. I had no doubts at all.

Senator ROTH. But none of them were paid?

Mr. SMITH. None of them was paid, not one penny, to my knowledge.

Senator ROTH. Thank you, Mr. Smith.

Ms. HOWELL. Mr. Chairman, I do have copies of statements of employee benefits where claims were paid by Travelers, and these obviously came from The Travelers office.

Senator NUNN. We will put that in the record and make it an exhibit, without objection.[1]

Senator NUNN. Thank you all for being here. We appreciate your cooperation and we hope that somehow this matter can be resolved more favorably to each of you, Mr. Smith, Mr. Frank, and Mr. Wagner. Thank you for your cooperation. I can assure you that what you have done here today will help this situation be corrected if at all possible. Thank you.

I believe that Commissioner Long may have an additional statement here briefly, and then we will go to our next witness. Mr. Long, you are still under oath, still a witness, as you were.

Mr. JIM LONG. Thank you, Mr. Chairman. I wanted to just come back for just a moment, Mr. Chairman, to explain to you. Now I think you understand why I asked you not to prejudge the issue of Travelers being on the risk or not on the risk. I think you and Senator Roth have a much more complete picture of it now, and I will assure you Senator that we are going through this process, we have with The Travelers, we have—and I think Ms. Howell will confirm this—have leaned on her and Mr. Stamey very heavily. We want to have these victims to be compensated, and we will continue that.

With that, Mr. Chairman, if it is agreeable with you, we would like very much to have a copy of the sworn testimony of these four witnesses. I think that will help us in our actions too.

Senator NUNN. Thank you. We will make those available to you.

Mr. JIM LONG. Thank you, sir.

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[1] Exhibit No. 4 has been retained in the Subcommittee files.

Senator NUNN. Thank you. Our next witness is Mr. Robert W. Long, president of Cap Staffing. Mr. Robert Long, would you come up.

Mr. Long, do you have an attorney with you?

Mr. ROBERT LONG. Yes, sir.

Senator NUNN. All right. Would the attorney introduce himself, and then I will give Mr. Long the oath.

Mr. MARTIN. Mr. Chairman, my name is Douglas Martin of the firm of Poyner & Spruill, and I am here representing the witness, Mr. Robert W. Long.

Senator NUNN. Thank you. Mr. Long, will you hold up your right hand and take the oath.

Do you swear the testimony you give before this Subcommittee will be the truth, the whole truth, and nothing but the truth so help you God?

Mr. ROBERT LONG. I do.

Senator NUNN. Mr. Long, if you would have a seat, we have just received testimony from several individuals who, though enrolled in the Cap Staffing Health Benefits Plan, have been unable to receive payment claims for medical services covered under that plan. And in light of that testimony, we obviously have a considerable number of questions we would like to ask you regarding the operation of Cap Staffing.

Could I start by asking you your full name and address for the record?

## TESTIMONY OF ROBERT W. LONG, PRESIDENT, CAP STAFFING, INC., ACCOMPANIED BY DOUGLAS MARTIN, ESQ., POYNER & SPRUILL

Mr. ROBERT LONG. My name is Robert Wayne Long. I live at 4821 Redbud Drive, Charlotte, NC.

Mr. MARTIN. Mr. Chairman, pardon my interruption. Mr. Long has prepared a brief written statement and in accordance with Rule 10 of the Subcommittee rules Mr. Long would like to read that. It was not submitted 48 hours in advance, but I have discussed the matter with your staff counsel, Mr. Alan Edelman, and I was informed this morning that he believed the Subcommittee would waive that 48-hour requirement. A copy has been provided to staff counsel prior to the hearing, and with the committee's permission, Mr. Long would like to read that brief statement.

Senator NUNN. We will permit that and we will waive the normal rule.

Let me just ask one or two more questions to Mr. Long. Mr. Long, Mr. Martin has identified himself. He is your attorney, is that right?

Mr. ROBERT LONG. Yes, sir.

Senator NUNN. OK. Go ahead and we will hear your statement.

Mr. ROBERT LONG. As an individual who has been involved in the business of staff leasing, I welcome the opportunity to address the Subcommittee and to share my views and experience on the subject.

Staff leasing can be beneficial to both the employee and the employer, particularly in the case of small businesses. The employee can receive a benefits package comparable to employees working for Fortune 500 companies. It has never seemed fair to me for someone who works hard in a restaurant or other small business to not be offered benefits that many employees, including government employees, take for granted.

Substantial benefits are also available to the employer who can use an enhanced benefits package to recruit and retain quality employees. With increased benefits comes increased loyalty to the company and enhanced productivity.

Although America has a history of a highly productive workforce and in recent years our productivity has fallen behind that of other nations with whom we must compete in the world marketplace. To the extent that productivity can be improved, the economy as a whole will benefit.

In addition, the employer who relies upon staff leasing can reduce or eliminate many administrative burdens. Such an employer can then concentrate on running his business, rather than having to devote substantial time and resources to handling the details of compliance with such programs as FICA, Federal and State unemployment insurance, INS, EEOC, and OSHA, and the various paperwork associated with such compliance.

An employer in the construction business once remarked that with staff leasing in place, he found that he could once again devote the majority of his time to productive work in the field, rather than to office paperwork.

Employee leasing offers one solution to these problems. I hate to see more regulations to control employee leasing companies, because increased regulations and the details of compliance with such regulations is the reason small businesses turn to employee leasing companies in the first place.

I do, however, see a need to control certain aspects of the staff leasing arrangements. Employee leasing companies should, in my judgment, restrict themselves to that industry and not become involved in the direct writing of insurance. No employee leasing company should be allowed to have a self-funded insurance plan.

In addition, because of the enormous amounts of money involved, I believe employee leasing companies should be required to have some sort of bonding arrangements. Such a requirement would offer protection both to the employer clients and to the employees of such businesses.

I believe that much can be accomplished through staff leasing to help people in this country and I wish to be fully cooperative in the inquiry of this subcommittee.

It has, however, come to my attention that there are investigations which may be in progress regarding some of the companies with which I have been associated. I have retained counsel who is with me today.

Upon advice of counsel, I may decline to answer certain questions on the basis of the fifth amendment. I am certain the subcommittee is aware of the purpose and scope of this privilege and I would not presume to instruct the committee as to matters of law.

However, because of the presence of other persons, including those who have testified and members of the press, I believe a brief explanation is appropriate.

Because the fifth amendment protects against possible self-incrimination, there is a common misconception that the privilege cannot be properly claimed by an innocent person. The U.S. Supreme Court has firmly rejected this view. Expressly condemning the idea of putting a sinister meaning to the exercise of such right, the Court said a witness may have a reasonable fear of prosecution and yet be innocent of any wrongdoing. The privilege serves to protect the innocent who otherwise might be ensnared by ambiguous circumstances.

People who have been involved with me since the inception of the Cap companies know the great love and concern I have for my family, my church, my country, and its people. Again, I consider it a privilege to have been asked to participate in these hearings before the U.S. Senate.

Senator NUNN. Thank you, Mr. Long.

We understand fully the implications of the fifth amendment and we respect all the witnesses' rights to all of their constitutional claims before this subcommittee.

I do want to ask you a few questions. I note here that you say that "in my judgment, employee leasing companies"—let me quote exactly—"employee leasing companies should, in my judgment, restrict themselves to that industry and not become involved in direct writing of insurance."

Did you not get involved in the writing of insurance through your leasing company?

Mr. ROBERT LONG. Yes, sir, we had an administrative services only contract with The Travelers.

Senator NUNN. And you believe that is not a good practice?

Mr. ROBERT LONG. Absolutely.

Senator NUNN. You think it should be barred?

Mr. ROBERT LONG. Yes, sir.

Senator NUNN. Why?

Mr. ROBERT LONG. Well, as I mentioned earlier, I think that the concept of employee leasing is a good concept and I feel very strongly that there is a need for it to help small businessmen, but most employee leasing companies could do a great job if they would just handle employees, recruit and hire and so forth of employees. But as far as running an insurance business, they do not know what they are doing there. I know I certainly did not.

Senator NUNN. So, that was a mistake, you believe, on your part?

Mr. ROBERT LONG. Yes, sir. As Ms. Howell mentioned, when I set up Cap Staffing, I spent an enormous amount of time and money making sure that it was put together right and legally and the person that I hired to run the insurance for me was introduced to me as the chairman or chief executive officer of The Travelers, the former chief executive officer, and I relied heavily on him.

Senator NUNN. What was his name?

Mr. ROBERT LONG. Ron Harris.

Senator NUNN. Who introduced you?

Mr. ROBERT LONG. An insurance agent in Charlotte by the name of Don Morrell.

Senator NUNN. And who is he? Is he with Travelers?

Mr. ROBERT LONG. He was with another insurance agency.

Senator Nunn. Did Mr. Harris hold himself out to be a former employee of Travelers?

Mr. Robert Long. Yes, sir.

Senator Nunn. A high executive in Travelers?

Mr. Robert Long. Yes, sir. As a matter of fact, he told me that if I would fly with him to Hartford, we could put an insurance package and benefits package together at The Travelers. I flew with him to Hartford.

Senator Nunn. You dealt directly with Travelers yourself?

Mr. Robert Long. Well, just on that one occasion. I did not really set up the plan or sign any contracts or anything like that. I just went with him to basically set up the plan itself.

Senator Nunn. Who did all of that with Travelers?

Mr. Robert Long. Ron Harris.

Senator Nunn. And did you find that what he was telling you was the truth? Was he indeed a former executive with Travelers?

Mr. Robert Long. The Travelers now claims he was not, but at that time I did not have any reason to doubt him. We were treated very royally when we went to Hartford.

Senator Nunn. Where is Mr. Harris now?

Mr. Robert Long. I have no idea.

Senator Nunn. Does that mean he has disappeared or does it just mean you have not kept up with him?

Mr. Robert Long. I understand he has disappeared.

Senator Nunn. Did he take some of the funds from the company that you were involved in?

Mr. Robert Long. As far as I know, all he took was his normal paycheck.

Senator Nunn. How much did he get paid?

Mr. Robert Long. I think he was on a salary of $60,000 a year, plus expenses.

Senator Nunn. How much did you get paid, Mr. Long?

Mr. Robert Long. I was on a salary of $10,000 a month.

Senator Nunn. $10,000 a month?

Mr. Robert Long. Yes, sir.

Senator Nunn. For what period of time?

Mr. Robert Long. I guess for about 3 years.

Senator Nunn. For about 3 years?

Mr. Robert Long. Yes.

Senator Nunn. Are you still drawing any salary?

Mr. Robert Long. No, sir.

Senator Nunn. When did that stop?

Mr. Robert Long. In August 1989.

Senator Nunn. Are you still President of Cap Staffing, Inc., of Charlotte, NC?

Mr. Robert Long. We have dissolved the corporation, sir.

Senator Nunn. How about Cap Leasing, Inc.?

Mr. Robert Long. That has all been dissolved.

Senator Nunn. And is that two separate corporations?

Mr. Robert Long. Yes, sir.

Senator Nunn. Prior to the formation—which was formed first, Mr. Long?

Mr. Robert Long. Cap Programs or Cap Leasing. Cap Programs, it was incorporated as Cap Programs. We called it Cap Leasing.

Senator NUNN. So, the real legal name was Cap Programs?

Mr. ROBERT LONG. Yes, sir.

Senator NUNN. That was formed first?

Mr. ROBERT LONG. Right.

Senator NUNN. Tell us a little bit about that company. What was that set up for?

Mr. ROBERT LONG. It was set up as a vehicle and equipment leasing company.

Senator NUNN. And when was Cap Staffing formed?

Mr. ROBERT LONG. I do not remember the exact date, but the actual incorporation was in the summer of 1988.

Senator NUNN. The summer of 1988?

Mr. ROBERT LONG. Right.

Senator NUNN. And what was the nature of that business? Why was that set up?

Mr. ROBERT LONG. It was set up to employ or go into businesses, take over their employees, put them on our payroll and lease them back to an employer.

Senator NUNN. And how does that help the employer?

Mr. ROBERT LONG. As I mentioned in my statement, it relieves him of a lot of administrative burdens. He writes one check to the employee leasing company and the employee leasing company takes care of all the payroll, the taxes, tax filings and so forth.

Senator NUNN. Are you saying that this concept is a good idea, even if you do not have any insurance involved in it?

Mr. ROBERT LONG. Yes, sir.

Senator NUNN. And it could be done independent of insurance, and in fact, it was done in some cases independent of insurance?

Mr. ROBERT LONG. Right.

Senator NUNN. What percentage of Cap Staffing's business related to what we would call, for the purposes of this hearing, at least, insurance, and what percentage of it was just strictly administrative?

Mr. ROBERT LONG. I do not know an exact——

Senator NUNN. Would it be about half and half?

Mr. ROBERT LONG. I would say about half and half. The percentages that Becky Howell quoted would be about right.

Senator NUNN. Mr. Long, what is your educational and employment background?

Mr. ROBERT LONG. I have a bachelor of arts degree in economics from UNCC and——

Senator NUNN. From where?

Mr. ROBERT LONG. UNCC, the University of North Carolina at Charlotte.

Senator NUNN. Right.

Mr. ROBERT LONG. And I had sold and leased dental equipment for a number of years up before establishing the Cap companies.

Senator NUNN. What is your background in the health insurance industry?

Mr. ROBERT LONG. I have none.

Senator NUNN. In a deposition taken on January 5, 1990, you testified under oath that prior to your association with Cap Staffing, you ran into "some legal problems" selling prepaid dental plans through a business called Family Dental Center. Could you explain—is that right—could you tell us about that experience?

[Pause.]

Mr. ROBERT LONG. On advice of counsel, I decline to answer that question on the grounds that it may tend to incriminate me.

Senator NUNN. You started Cap Staffing about the summer of 1988, did you not?

Mr. ROBERT LONG. Yes, sir.

Senator NUNN. At that time, you entered into negotiations with the Travelers Insurance Co., Hartford, CT, relating to a health benefits plan, is that correct?

Mr. ROBERT LONG. Yes, sir.

Senator NUNN. As a result of your negotiations with Travelers, did Cap Staffing and Travelers come to an agreement relating to Cap's health benefits plans?

Mr. ROBERT LONG. At that meeting?

Senator NUNN. Well, at any time.

Mr. ROBERT LONG. Yes, sir, at that meeting—I am sorry, at the meeting when I went to Hartford, we reached an agreement.

Senator NUNN. Was that reduced to writing?

Mr. ROBERT LONG. If there is anything in writing about it, Ron Harris would have received any of the information.

Senator NUNN. You did not sign anything at that meeting?

Mr. ROBERT LONG. No, sir.

Senator NUNN. Did you later on sign something?

Mr. ROBERT LONG. I did not.

Senator NUNN. So, maybe Ron Harris did?

Mr. ROBERT LONG. Right.

Senator NUNN. What was his official position with your company?

Mr. ROBERT LONG. He was vice president.

Senator NUNN. Did he have full authority to sign contracts on behalf of the company?

Mr. ROBERT LONG. Yes, sir.

Senator NUNN. Could you tell us the nature of the agreement that you had, whether it was oral or in writing, with Travelers?

Mr. ROBERT LONG. I would say it was more of an oral agreement. All I saw was an oral—all I was involved in was the meeting at Hartford.

Senator NUNN. And what was your understanding about what your company would do and what Travelers would do for you and for your clients?

Mr. ROBERT LONG. My understanding was that Travelers would process all the claims, handle all the claims, pay the claims and they would tell us how much we had to reimburse them for the claims and they would also charge us an administrative fee for handling the claims for us.

Senator NUNN. Did you believe they were backing the claims themselves?

Mr. ROBERT LONG. Yes, sir, I did.

Senator NUNN. So, you felt that Travelers was backing the claims in exchange for what you were doing with them?

Mr. ROBERT LONG. Right.

Senator NUNN. So, you felt if something went wrong with your company, that they would step in and take care of the benefits?

Mr. ROBERT LONG. Yes, sir, I did.

Senator NUNN. Even if you could not reimburse them fully?

Mr. ROBERT LONG. Well, I did not see that as being a problem, so I guess I did not think about it.

Senator NUNN. You did not think about it, but that was your assumption?

Mr. ROBERT LONG. Yes, sir.

Senator NUNN. You felt, then, in effect, they were a re-insurer?

Mr. ROBERT LONG. That is exactly what I felt.

Senator NUNN. Did you believe that Cap Staffing's health benefits plan was a self-funded plan?

Mr. ROBERT LONG. The way the plan was described to me, as I said, at that time I knew nothing about insurance, but Ron Harris said that we had a stop loss on each individual and I think it was $25,000, and we had an aggregate loss, so, you know, it was going to be virtually impossible, because of the large numbers of people that we were putting on, that we would ever reach that aggregate loss.

Senator NUNN. What was that?

Mr. ROBERT LONG. $750,000, I believe. I am not positive, but I believe it was $750,000.

Senator NUNN. How many employers—I will ask you really two questions—how many employers you eventually helped insure and how many employees did you help insure? Do you know the scope of your coverage, how many employees? The main thing is employees. Generally speaking, do you have any idea?

Mr. ROBERT LONG. I think that we had—well, I had another fellow that I hired from the Travelers named Earl Hewitt, who had his own Travelers agency in Pennsylvania, and he at one time told me in May before I sold the company out that we had over 3,000 people insured and were getting in approximately $275,000 a month in premiums.

Senator NUNN. $275,000 per month from premiums?

Mr. ROBERT LONG. Right. I do not know what percentage was——

Senator NUNN. So, that would be, what, $3 million a year from premiums?

Mr. ROBERT LONG. Right.

Senator NUNN. Do you know how much was being paid out during that time?

Mr. ROBERT LONG. You mean paid out in claims?

Senator NUNN. Yes.

Mr. ROBERT LONG. Before I sold out, the total claims that we had was a little better than $200,000, which I had sent to the Travelers.

Senator NUNN. Before you sold out. When did you sell out?

Mr. ROBERT LONG. In late May 1989.

Senator NUNN. To whom did you sell?

Mr. ROBERT LONG. I sold to a company out of Florida, Stuart, FL, called Gold Equity Management Co.

Senator NUNN. Who are the principals in that company?

Mr. ROBERT LONG. Michael Spieles and Michael Krebser.

Senator NUNN. And where do they live?

Mr. ROBERT LONG. Stuart, FL.

Senator NUNN. Now, when you sold out, did Mr. Harris still work for you or did he work for them, or did he just leave?

Mr. ROBERT LONG. He worked for me.

Senator NUNN. He stayed with you?

Mr. ROBERT LONG. Right. We had an arrangement that we were going to work with GEMCO, we had an arrangement we were going to work with GEMCO.

Senator NUNN. Who is that?

Mr. ROBERT LONG. Gold Equity Management Co.

Senator NUNN. So, you were going to still do work with them?

Mr. ROBERT LONG. Yes, sir.

Senator NUNN. They were going to be the owners, but you were going to still operate it?

Mr. ROBERT LONG. Right, and I was to keep a minority interest in it.

Senator NUNN. And did that deal go through?

Mr. ROBERT LONG. Yes, sir.

Senator NUNN. And is it still in effect?

Mr. ROBERT LONG. No, sir. After I sold out to them, they did not pay any bills or any claims or anything and so I tried to take the company back over and get it right, and it was just too much wrong then. They changed the name of it at that time to Universal Staffing. Of course, they kept all the clients of Cap and the sales force and so forth, so there was nothing to recoup there.

Senator NUNN. How long did that arrangement last before you decided it was too far gone?

Mr. ROBERT LONG. To the middle or end of July 1989.

Senator NUNN. And it was sold in May or June?

Mr. ROBERT LONG. Late May or the first of June.

Senator NUNN. So, it lasted only a month and a half or 2 months?

Mr. ROBERT LONG. Two months, yes, sir.

Senator NUNN. And what happened then?

Mr. MARTIN. Could I ask the Chairman to be a little more specific?

Senator NUNN. Well, what happened to the company then? Did you take it back over or did you just dissolve it?

Mr. ROBERT LONG. I took it back over for a short while and then we closed the doors, it was put into bankruptcy.

Senator NUNN. Did you enter into a cancellation and rescission agreement, dated July 31, 1989?

Mr. ROBERT LONG. Yes, sir, I did enter into that agreement. If I can explain about that——

Senator NUNN. Surely.

Mr. ROBERT LONG. At that time of my life, I was in a very deep depression. You know, when I had sold out, some of the promises made to me were the fact that the employee leasing company would stay in Charlotte, North Carolina, all the employees would be held, a letter was written to that effect and so forth. Then they said because of bad publicity, you know, if we wanted to get the Travelers and some other people paid, we had to change the name of the company to Universal Staffing. I agreed to go along with that and sell for Universal Staffing.

Senator NUNN. In that agreement——

Mr. **Robert Long**. But I did not read that agreement when I signed it, I am sorry to say.

Senator **Nunn**. You did not read it?

Mr. **Robert Long**. No, sir.

Senator **Nunn**. You did not have an attorney there?

Mr. **Robert Long**. No, sir.

Senator **Nunn**. In that agreement, the third whereas on page 1 says, "Whereas, The said representatitions and disclosures made or to be made to Spieles and Krebser have either been false and misleading or been incomplete, or inadequate, thereby making it impossible for Spieles and Krebser to accomplish the goals and objectives contemplated by the parties thereto." Do you remember that?

Mr. **Robert Long**. I did not read it. I have read it since then, but I did not read that when I signed it, sir.

Senator **Nunn**. So, was Mr. Harris with you when you signed this?

Mr. **Robert Long**. No, sir.

Senator **Nunn**. You signed it by yourself?

Mr. **Robert Long**. He may have been with me, but I cannot say——

Senator **Nunn**. But you had no attorney there?

Mr. **Robert Long**. No, I did not. I was using their in-house attorney.

Senator **Nunn**. It is just a 3-page document, it is not a long document, but you did not read it at all?

Mr. **Robert Long**. No, sir, I did not.

Senator **Nunn**. Was that your normal habit, not reading?

Mr. **Robert Long**. Unfortunately, I just signed things without reading them.

Senator **Nunn**. Is that statement true or false?

Mr. **Robert Long**. That is a false statement.

Senator **Nunn**. So, that is not an accurate portrayal of your representations to this group?

Mr. **Robert Long**. I gave them a complete and total representation and told them one of the big problems we had is we had sent out payroll checks and had accounts receivables outstanding of over $500,000. The administrative part, I have virtually no administrative capabilities and the administrative part was just too overwhelming for me.

Senator **Nunn**. Mr. Long, Travelers Insurance Company has submitted a statement for the record, part of which reads as follows—let me read it to you and then get you to comment on this: "During September or October 1988, a Travelers representative in Charlotte, North Carolina submitted a proposal to Cap Staffing for life, accidental death and dismemberment and health insurance coverage on a fully insured basis. Cap Staffing rejected this proposal."

Let me stop there. Maybe you could comment on each paragraph. That is the first paragraph. Would you prefer me to read the whole thing and then come back?

Mr. **Robert Long**. If you would, please.

Senator **Nunn**. All right. Let me go ahead.

"Subsequently, Long and Harris contacted Travelers' home office and arranged a meeting to discuss other possible arrangements through which Travelers could assist Cap Staffing in providing an employee benefit plan to its employees. Long and Harris then flew to Hartford, Connecticut and met with Travelers' representatives.

"On or about late October 1988, Travelers' home office offered Cap Staffing an ASO—Administrative Services Only—contract, under which Travelers would simply administer or process health claims for Cap Staffing's employee health benefits plan. Travelers did not underwrite or insure Cap Staffing's employee health benefits plan. Cap Staffing's employee health benefits plan was to be a self-funded plan, which would be funded using payroll deductions. Travelers would be reimbursed for claims processed and paid through a bank account Cap Staffing agreed to establish at Connecticut National Bank in Hartford, Connecticut."

Would you tell us what your own feeling is about that statement from Travelers? Are there parts of it you disagree with, or do you agree with all of it?

Mr. ROBERT LONG. I agree with all of it. When we first approached the local Travelers office, Ron Harris said that this is not a favorable contract. He said I have contacts in Hartford at the Travelers. You know, he was a major figure there, and he said we can travel to Hartford and get the kind of contract that we want.

Senator NUNN. You say you agree with all of it, but in this statement, it says Travelers did not underwrite or insure Cap Staffing's employee health benefits plan.

Mr. ROBERT LONG. Oh, I am sorry. It was my understanding that we had, as I said, a minimum that we would have to cover and an aggregate stop loss.

Senator NUNN. And that they would cover the rest?

Mr. ROBERT LONG. Right.

Senator NUNN. So, you do not agree with that part of the statement?

Mr. ROBERT LONG. Right. We should have gone paragraph by paragraph. I am sorry.

Senator NUNN. So, you do not agree with the statement where it says "Travelers did not underwrite or insure Cap Staffing's employee health benefits plan"?

Mr. ROBERT LONG. No, sir, I do not agree with that.

Senator NUNN. You felt they did?

Mr. ROBERT LONG. Yes, sir.

Senator NUNN. Did Cap Staffing, in fact, establish a bank account at Connecticut National Bank, in Hartford, CT?

Mr. ROBERT LONG. Yes, sir.

Senator NUNN. Was that account funded as required under the agreement with Travelers?

Mr. ROBERT LONG. Upon advice of counsel, I decline to answer that question on the grounds that it may tend to incriminate me.

Senator NUNN. OK. Let me read you this other statement from Travelers. Travelers' statement for the record also states, "On or about December 7, 1988, Cap Staffing submitted forms to Connecticut National Bank for the purported establishment of a bank account. However, Cap Staffing failed to fund the bank account, as agreed in the ASO contract, except to the limited extent indicated in paragraph 20 below. Joanie Self, a bookkeeper at Cap Staffing, apparently made numerous efforts to fund the bank account, but was ordered not to do so by Harris, Long or others." Could you tell me about the accuracy of that statement, whether it is accurate?

Mr. ROBERT LONG. My answer is the same.

Senator NUNN. The same as what? We have had a lot of answers, so you had better make it clear here.

Mr. ROBERT LONG. Upon advice of counsel, I decline to answer that question on the grounds that it may tend to incriminate me.

Senator NUNN. Do you know Joanie Self?

Mr. ROBERT LONG. Yes, sir.

Senator NUNN. What was her position in Cap Staffing?

Mr. ROBERT LONG. She was a secretary.

Senator NUNN. A secretary?

Mr. ROBERT LONG. Yes, sir.

Senator NUNN. Did she also keep the books?

Mr. ROBERT LONG. No, sir.

Senator NUNN. She had nothing to do with bookkeeping?

Mr. ROBERT LONG. She wrote checks. She wrote and signed checks.

Senator NUNN. Who kept the books?

Mr. ROBERT LONG. At that time, George Moore, a CPA.

Senator NUNN. And she did not do any bookkeeping? Writing checks is a form of bookkeeping, is it not?

Mr. ROBERT LONG. Yes, sir, she wrote checks and I think she kept up with some of the claims and so forth.

Senator NUNN. But you would consider her a secretary?

Mr. ROBERT LONG. Yes, sir.

Senator NUNN. Did she work under your supervision, as president of Cap Staffing?

Mr. ROBERT LONG. She would have worked directly for Jerry Wolicki, who was the President and office manager.

Senator NUNN. Did you ever give her orders yourself, or was everything——

Mr. ROBERT LONG. I gave her orders myself, too, yes, sir.

Senator NUNN. So, she worked for you also?

Mr. ROBERT LONG. Right.

Senator NUNN. Did you ever tell Joanie Self or any other person that Travelers Insurance Co. was the carrier for health benefits offered by Cap Staffing?

Mr. ROBERT LONG. Yes, sir.

Senator NUNN. You did?

Mr. ROBERT LONG. Yes, sir.

Senator NUNN. That is what you thought?

Mr. ROBERT LONG. Yes, sir.

Senator NUNN. Were you aware that the Cap Staffing health benefits plan was being marketed as a plan insured by Travelers Insurance Co.?

Mr. ROBERT LONG. Would you say that again, please? I am sorry.

Senator NUNN. Were you aware that Cap Staffing's health benefits plan was being marketed as a plan insured by Travelers Insurance Co.?

Mr. ROBERT LONG. Yes, sir.

Senator NUNN. You thought that was what was happening, right?

Mr. ROBERT LONG. Yes, sir.

Senator NUNN. And you intended for that to happen?

Mr. ROBERT LONG. Absolutely.

Senator NUNN. Do you know Rebecca Howell?

Mr. ROBERT LONG. Yes, sir.

Senator NUNN. Let me read you—who was she?

Mr. ROBERT LONG. She was a partner in Stamey-Howell, a small insurance agency in Kannapolis.

Senator NUNN. And they worked with you?

Mr. ROBERT LONG. Yes, sir.

Senator NUNN. Let me read you a statement from Ms. Howell's testimony here this morning, and if you have a part of it you want me to stop on, let me know and I will, but I will read the whole thing and then we will come back—from Ms. Howell's testimony:

> Rick Stamey and I decided to attend the August 31 meeting to hear more about Cap Staffing. There were approximately 200 people there. The meeting lasted the entire morning and there were several speakers who covered various aspects of Cap Staffing. One speaker was Ron Harris, who was introduced by Mr. Bob Long, as a former CEO of the Travelers.

Is that right, did you introduce him as a former CEO of the Travelers?

Mr. ROBERT LONG. Yes, sir, I did.

Senator Nunn [reading]. "Mr. Harris spoke on the group health insurance benefits which would be offered to employees of companies enrolling in the Cap Staffing employee leasing program. Those attending the meeting were furnished with a brochure summarizing the plan. Those brochures bore the Travelers name and logo and gave every indication that the plan was a Travelers group policy."

Do you agree with that?

Mr. ROBERT LONG. Yes, sir.

Senator Nunn [reading]. "One page of the brochure even referred to the plan as 'the Travelers plan' and the 'Travelers policy' "—I am continuing the quote from Ms. Howell's testimony—"and stated that the benefits were governed by the insurance contract. Nowhere in that brochure was there anything to indicate the plan was anything other than a group insurance policy," from Ms. Howell.

Do you recall being present at that meeting?

Mr. ROBERT LONG. Yes, sir.

Senator NUNN. Is that an accurate portrayal of what happened there?

Mr. ROBERT LONG. Yes, sir.

Senator NUNN. Do you agree with Ms. Howell's statement here?

Mr. ROBERT LONG. Yes, sir.

Senator NUNN. No parts of it do you disagree with?

Mr. ROBERT LONG. No, sir.

Senator NUNN. Let me read you a statement again——

Mr. MARTIN. The Senator was intending to refer to that portion which was just quoted, is that correct?

Senator NUNN. That is correct, just the portion I read.

Mr. MARTIN. Thank you.

Senator NUNN. Let me read again the statement submitted for the record by Travelers Insurance Co.: "Travelers believes that Cap Staffing fraudulently represented to employers and employees that

Travelers was the underwriter or insurance carrier for Cap Staffing's health benefits plan and that Cap Staff intentionally failed to reveal the self-funded nature of its employee health benefits plan, so that by misusing Travelers' good will and good name, Cap Staffing could deduct insurance premiums from the paychecks of employees and convert those premiums to personal or other uses of the Cap entities and the Cap principals, rather than fund the bank account."

How would you respond to that statement by Travelers?

Mr. ROBERT LONG. Well, my statement would be that, as I mentioned earlier, I went to great expense and time to make sure everything was put together legally and I personally never tried or intended to commit any type of fraud whatsoever or misrepresent anything.

Senator NUNN. Well, you would disagree with this statement, then?

Mr. ROBERT LONG. Yes, sir.

Senator NUNN. Under the Administrative Services Only agreement with Travelers, Cap Staffing was required to maintain an account for payment for benefit claims, is that correct?

Mr. ROBERT LONG. Yes, sir.

Senator NUNN. Did Cap Staffing, did your company make the required payments to that claims account?

Mr. ROBERT LONG. Upon advice of counsel, I decline to answer that question, on the grounds that it may tend to incriminate me.

Senator NUNN. Did you ever contact or direct Joan Self or anyone else to take money out of that account to be used for other purposes?

Mr. ROBERT LONG. Upon advice of counsel, I decline to answer that question, on the grounds that it may tend to incriminate me.

Senator NUNN. Did you order Joan Self to pay Cap Programs investors with monies from the Cap Staffing claims account?

Mr. ROBERT LONG. Upon advice of counsel, I decline to answer that question, on the grounds that it may tend to incriminate me.

Senator NUNN. Were you aware that money from the Cap Staffing claims account was used to cover payroll?

Mr. ROBERT LONG. My answer is the same.

Senator NUNN. Who is Jerry Wolicki, if I am pronouncing that correctly?

Mr. ROBERT LONG. Jerry Wolicki was an owner in Cap Staffing and was I think a vice president of the company. He ran the office, was the office administrator or office boss, I guess.

Senator NUNN. Joan Self's affidavit, which we will make a part of the record and it will be appropriately identified and exhibited in number, without objection, Joan Self's affidavit says the following:

> Jerry Wolicki had me pay off his credit cards. I never received an explanation of the charges, such as a statement, just the payment stub from the statement to send with each payment. I made two individual payments of $3,500 each before turning over the books to the new accountant. Jerry Wolicki said all the charges were Cap Staffing, but the card and the bill were made out to Jerry Wolicki, not Cap Staffing, Inc.[1]

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[1] See Exhibit No. 5 on p. 186.

Do you agree with that statement by Joan Self?

Mr. ROBERT LONG. I have no knowledge of that statement and cannot agree or disagree.

Senator NUNN. Joan Self also—you cannot answer that question, then?

Mr. ROBERT LONG. Right.

Senator NUNN. You do not know whether it is right or wrong?

Mr. ROBERT LONG. That is correct.

Senator NUNN. Joan Self also said: "Whenever I questioned Ron Harris"—this was in her affidavit—"whenever I questioned Ron Harris about the balance of this claim account and the required amount we should be depositing, he would inform me that we only needed to keep a balance of $11,000 in the account. Once, when I tried to make out a deposit on the claims account to cover the check that Ron Harris had wrote to cover payroll, an additional amount, Bob Long had me void the deposit and give half the money to Cap Programs. When I questioned this, I was told not to worry about it, it was his company."

Do you recall that?

Mr. ROBERT LONG. Upon advice of counsel, I decline to answer that question, on the grounds that it may tend to incriminate me.

Senator NUNN. Joan Self goes on to say: "By February 1989, Bob Long was having me transfer money to Cap Programs so often that I had to meet payroll, payroll taxes and accounts payable before Bob found out the balance of the working account."

Would you comment on that?

Mr. ROBERT LONG. My answer is the same.

Senator NUNN. What was your salary again, as president of Cap Staffing?

Mr. ROBERT LONG. $10,000 a month.

Senator NUNN. And you received that for approximately 3 years?

Mr. ROBERT LONG. Correct.

Senator NUNN. So, you drew approximately $360,000 over 3 years from that account?

Mr. ROBERT LONG. That is correct.

Senator NUNN. Aside from your salary, what other income did you receive from Cap Staffing?

[Pause.]

Mr. ROBERT LONG. Upon advice of counsel, I decline to answer that question, on the grounds that it may tend to incriminate me.

Senator NUNN. Senator Roth.

Senator ROTH. Mr. Long, was Travelers ever given copies of the employee benefits book of Cap Staffing, Inc.?

Mr. ROBERT LONG. Travelers printed those.

Senator ROTH. These books were actually printed by——

Mr. ROBERT LONG. Yes, sir.

Senator ROTH. Are you familiar with the substance of this booklet?

Mr. ROBERT LONG. As Senator Nunn said earlier, I probably just read the first page of it, and that was it.

Senator ROTH. You only read the first page. Now, the first page contains a summary plan description and certificate of insurance under the group life and health insurance plan for employees of

Cap Staffing, Inc., insured by the Travelers Insurance Co., so you were familiar with this first page?

**Mr. ROBERT LONG.** Yes, sir.

**Senator ROTH.** This statement was signed on behalf of the Travelers Insurance Co. by Joseph Brophy. Who was he?

**Mr. ROBERT LONG.** I do not know.

**Senator ROTH.** You have no knowledge?

**Mr. ROBERT LONG.** No.

**Senator ROTH.** Did you believe that this statement accurately reflected the situation with Travelers?

**Mr. ROBERT LONG.** Yes, sir.

**Senator ROTH.** That is all, Mr. Chairman.

**Senator NUNN.** Mr. Long, just a few more questions. Are you now affiliated with a company called Pro-Staff Management Systems, Inc.?

**Mr. ROBERT LONG.** Yes, sir.

**Senator NUNN.** When was that one incorporated?

**Mr. ROBERT LONG.** October 1989.

**Senator NUNN.** October 1989. Was that formed by you?

**Mr. ROBERT LONG.** Yes, sir.

**Senator NUNN.** And your wife?

**Mr. ROBERT LONG.** Yes, sir.

**Senator NUNN.** What is her name?

**Mr. ROBERT LONG.** Laurie.

**Senator NUNN.** Is the Pro-Staff Management Systems, Inc. company also an employee leasing company?

**Mr. ROBERT LONG.** We originally set up as an employee leasing company, because I could not use the name Cap Staffing any more, so I changed the name because I really believed in the employee leasing business. We are no longer in the employee leasing business, though.

**Senator NUNN.** What about health benefits? Does Pro-Staff offer a health benefits plan as part of its program?

**Mr. ROBERT LONG.** We were going to offer health benefits, but we never signed anybody up. We never sold any plans.

**Senator NUNN.** You are not doing that now?

**Mr. ROBERT LONG.** Well, since that time, I have acquired my insurance license and I am now selling insurance plans.

**Senator NUNN.** You are selling insurance plans now?

**Mr. ROBERT LONG.** Yes, sir.

**Senator NUNN.** In the State of North Carolina?

**Mr. ROBERT LONG.** Yes, sir.

**Senator NUNN.** What kind of insurance are you selling?

**Mr. ROBERT LONG.** Accident, health and life.

**Senator NUNN.** How much have you sold?

**Mr. ROBERT LONG.** Well, I have just gotten started in it, so——

**Senator NUNN.** When did you get your license?

**Mr. ROBERT LONG.** About a month and a half ago.

**Senator NUNN.** Have you got it with you?

**Mr. ROBERT LONG.** No, sir.

**Senator NUNN.** Do they issue a certificate or a piece of paper, or what?

**Mr. ROBERT LONG.** They mailed a card. I do not have it with me, though.

Senator NUNN. And you are sure of that?

Mr. ROBERT LONG. Yes, sir. Well, I called the Insurance Commissioner's office after I received the notice that I had passed the test and everything and they said that—they gave me the date that the card was mailed out, so——

Senator NUNN. And you have the card?

Mr. ROBERT LONG. I do not have it on me, no, sir. I called and told them I did not receive the card and they said it was mailed, so I——

Senator NUNN. But did you ever receive it?

Mr. ROBERT LONG. No, sir.

Senator NUNN. You did not receive it, but you were told orally on the phone that you had it?

Mr. ROBERT LONG. Yes, sir. I called the Insurance Commissioner's office.

Senator NUNN. That it was in the mail?

Mr. ROBERT LONG. Yes, sir.

Senator NUNN. And what kind of insurance have you sold?

[Pause.]

Mr. ROBERT LONG. The type of insurance that I have sold at this point is just some accident and disability. I have not even turned those in yet. It is to be payroll deducted and I was just getting enrolled with Colonial out of Columbia, SC.

Senator NUNN. You feel you are qualified to sell insurance?

Mr. ROBERT LONG. I do now, yes, sir.

Senator NUNN. You have learned a lot?

Mr. ROBERT LONG. Boy, have I ever.

Senator NUNN. Have you represented to anyone that a health benefits plan offered through Pro-Staff was underwritten by Blue Cross-Blue Shield, did you ever represent that?

Mr. ROBERT LONG. We were going to sell Blue Cross-Blue Shield. We had gotten set up to sell Blue Cross-Blue Shield, but I never sold any of it, but we were——

Senator NUNN. You were prepared to?

Mr. ROBERT LONG. Yes, sir.

Senator NUNN. What changed your mind about that?

Mr. ROBERT LONG. We never sold any employee leasing. I was determined—all we were going to sell was the employee leasing, the full-service leasing.

Senator NUNN. Do you recall ever making statements about Blue Cross-Blue Shield to Neil Campbell and Don Bonds of Bonds Distributing Company, somewhere in October 1989?

Mr. ROBERT LONG. I went to visit Don Bonds. I received a letter from Becky Howell about the case of Susan Franks and I was pretty sick to my stomach. One thing that I did, my wife and I were very, very upset. I called my secretary at Pro-Staff and told her to please get in touch with Becky Howell and let her know that if we had to sell our house to get that little girl in the hospital and get her taken care of, that we would somehow or other take care of it. Then I went to Don Bonds, you know, to meet with him to see how Susan Franks was doing and he asked what I—he had informed me that Universal Staffing had agreed to take care of the claims and so forth, and he asked what I was doing and I said that we were going to—that I was getting back into an employee leasing company that was going to be through Blue Cross-Blue Shield and it would be a fully insured program, not a self-funded program.

Senator NUNN. Did you think you had that agreement with Blue Cross-Blue Shield at that time?

Mr. ROBERT LONG. I never met with the Blue Cross-Blue Shield representative, but Pat Hilton, who worked at Pro-Staff, did.

Senator NUNN. Let me just ask you one final set of questions here. You testified, I believe, today and also in your January 5 deposition, that you were receiving insurance premiums in the amount of $275,000 a month, approximately, is that right?

Mr. ROBERT LONG. Yes, sir.

Senator NUNN. In the Cap Staffing Company?

Mr. ROBERT LONG. Yes, sir.

Senator NUNN. Was the $275,000—what happened to it, once it came in? What did you do with it?

Mr. ROBERT LONG. Upon advice of counsel, I decline to answer that question, on the grounds that it may tend to incriminate me.

Senator NUNN. Was any of the $275,000 collected each month used for purposes other than the reimbursement of Travelers for the payment of insurance claims?

Mr. ROBERT LONG. My answer is the same.

Senator NUNN. In his deposition—have you read Mr. Ron Harris' deposition?

Mr. ROBERT LONG. No, sir.

Senator NUNN. Have you had that, counsel? Have you seen the Ron Harris deposition?

Mr. MARTIN. In which litigation is that, may I ask the Chairman?

Senator NUNN. It is a deposition in the General Court of Justice Superior Court, State of North Carolina, *North Carolina Federal Savings & Loan Association* v. *Cap Staffing, Inc.*, dated December 5, 1989.

Mr. MARTIN. I do not believe we have that deposition.

Senator NUNN. All right. Well, let me just ask you one question. I will quote from it. In his deposition, Mr. Ron Harris was asked about the disposition of various monies collected by Cap Staffing. He responded, "I don't know where it would have gone. I've heard all kinds of rumors, but it had to go somewhere."

Mr. Harris was then asked, "Well, what rumors have you heard?" Mr. Harris answered, "Oh, I've heard that there was money put in the Cayman Islands and things like that." Mr. Harris was asked, "By Mr. Long? Answer: Yes, sir."

I ask you, Mr. Long, was some of this money put in bank accounts outside the United States?

Mr. ROBERT LONG. No, sir.

Senator NUNN. No money went outside the United States?

Mr. ROBERT LONG. No, sir.

Senator NUNN. Would you tell us, then, what happened to the money?

Mr. ROBERT LONG. Upon advice of counsel, I decline to answer that question, on the grounds that it may tend to incriminate me.

Senator NUNN. Did you use it for your personal use, beyond your salary?

Mr. ROBERT LONG. My answer is the same.

Senator **Nunn**. Did you take a cruise in the Caribbean in March of this year?

Mr. **Robert Long**. This year?

Senator **Nunn**. Yes.

Mr. **Robert Long**. No, sir.

Senator **Nunn**. How about 1989?

Mr. **Robert Long**. In 1989, I did.

Senator **Nunn**. Did that cruise—where did it go?

Mr. **Robert Long**. It went to Cozumel, Mexico, Grand Cayman Islands—my wife and I got off in Grand Cayman Islands and went on from there to Jamaica and the Bahamas, I think.

Senator **Nunn**. The Bahamas?

Mr. **Robert Long**. And back to Miami.

Senator **Nunn**. Did you conduct any business on that trip?

Mr. **Robert Long**. No, sir.

Senator **Nunn**. You didn't conduct any business in the Cayman Islands?

Mr. **Robert Long**. No, sir.

Senator **Nunn**. Did not set up any bank accounts?

Mr. **Robert Long**. No, sir.

Senator **Nunn**. In the Bahamas?

Mr. **Robert Long**. No, sir.

Senator **Nunn**. How much did the trip cost you, do you remember?

Mr. **Robert Long**. Approximately $3,000.

Senator **Nunn**. Do you spend a lot of money in your personal life?

[Pause.]

Mr. **Robert Long**. At the present time, no, sir. [Laughter.]

Senator **Nunn**. We will leave it at that. Thank you, Mr. Long. We will have other questions for you later. We hope that at some point in the future you will be able to tell us what happened to all the money and we hope you will be able to tell us everything about this company, because we are trying to discover how we can avoid this sort of situation in the future.

You have seen the people who are victims here this morning, have you not?

Mr. **Robert Long**. Yes, sir.

Senator **Nunn**. How do you feel about that, people who do not have any insurance, people who cannot pay their bills, people that are destitute?

Mr. **Robert Long**. My whole insides are eaten out and I would just love to be able to be able to help them. My insides have been eaten out, like I said, for a year now, since this happened, and I have been through a severe depression because of it.

Senator **Nunn**. Mr. Long, we regret that you are not answering all the questions. We recognize your right, however, to invoke the protections of the Constitution and we appreciate your being here, Mr. Martin.

Mr. **Martin**. As the chairman is aware, the witness' refusal is on my advice and recommendation.

Senator **Nunn**. We understand that. Thank you.

Our last panel will address current Federal policy regarding the regulation of multiple-employer health plans, as well as the concerns that have been raised by the previous witness about the potential for fraud and abuse in these plans.

Testifying as part of this panel will be Mr. David Ball, the Assistant Secretary of Labor for Pension and Welfare Benefits; Mr. Raymond Maria, the Acting Inspector General for the Department of Labor; and Mr. Jim Moody, Section Chief of the Organized Crime Section of the Federal Bureau of Investigation.

Gentlemen, we are pleased to have all of you. I think probably all of you are familiar with our rules and I will ask you, before you take your seats, if you will take the oath.

Do each of you swear that the testimony you give before this subcommittee will be the truth, the whole truth, and nothing but the truth, so help you, God?

Mr. **Ball**. I do.

Mr. **Maria**. I do.

Mr. **Moody**. I do.

Senator **Nunn**. Mr. Ball, I suppose we will get you to lead off here this morning. We are glad to have you.

## TESTIMONY OF DAVID GEORGE BALL, ASSISTANT SECRETARY FOR PENSION AND WELFARE BENEFITS ADMINISTRATION,[1] ACCOMPANIED BY ALAN D. LEBOWITZ, DEPUTY ASSISTANT SECRETARY FOR PROGRAM OPERATIONS, U.S. DEPARTMENT OF LABOR

Mr. **Ball**. Thank you, Mr. Chairman.

I am the Assistant Secretary of Labor for Pension and Welfare Benefits. Accompanying me is Mr. Alan Lebowitz, the Deputy Assistant Secretary for Program Operations. Also present, Mr. Chairman, is Mr. Robert Davis the Solicitor of Labor.

We are pleased to appear before you today to report on the Department of Labor's regulatory and enforcement efforts, including the assistance we are providing to State regulators regarding to multiple-employer welfare arrangements, which are known as MEWA's.

At the outset, I would like to outline the current Federal-State regulatory structure as it relates to MEWA's. The current regulatory structure establishes concurrent Federal-State jurisdiction in the regulation of MEWA's. The Department of Labor has responsibility for the administration and enforcement of Title I of the Employee Retirement Income Security Act of 1974, known as ERISA.

ERISA, among other things, establishes fiduciary and other standards for employer-sponsored health plans and broadly preempts State laws regarding to such plans. ERISA's broad preemption provisions generally reserve sole regulatory and enforcement authority over employee benefit plans to the Federal Government. There is, however, an exception from ERISA's preemption provisions for State laws which regulate insurance.

For many years, promoters have established trusts, so-called multiple-employer welfare arrangements, MEWA's, which are set up to market health and welfare benefits to small companies for their employees. MEWA's are often marketed at premium rates that are substantially below rates for comparable insurance coverage from insurance companies and are, thus, especially attractive for smaller businesses who find it very difficult to obtain an affordable health program for their employees.

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[1] See p. 150 for Mr. Ball's prepared statement.

In concept, MEWA's would appear to fill an important void in health care availability. In practice, they may be subject to abuse. This is because they may have inadequate reserves and, therefore, be unable to pay claims. In the worst situation, they may be run by individuals who bleed them dry through extraordinarily high fees and outright embezzlement.

While we cannot estimate the number of MEWA's run by unscrupulous promoters, each time a MEWA fails, hundreds and perhaps thousands of participants are left without health coverage for which they paid.

Because MEWA's are organized as trusts, they may seek to avoid regulation by State insurance authorities regarding such matters as required reserves and contributions. They may do this by claiming that ERISA's broad preemption provisions prohibit States from imposing such requirements.

However, in the 16 years since ERISA's enactment, it has been extraordinarily rare for the department to find a MEWA to be immune from State insurance regulation, because of ERISA's preemption provisions. Furthermore, Congress amended ERISA in 1983, to make clear that States would be free to regulate these programs under their insurance regulations, without risk of ERISA preemption.

I would now like to turn to a discussion of the States and the Department in regulating MEWA's. Unlike State insurance laws, ERISA does not contain any reserve or contribution requirements for health plans. In addition, there are no rules similar to State insurance requirements relating to the qualifications of persons who operate insurance companies or sell insurance.

Thus, while the Department may be able to enforce the ERISA fiduciary standards and applicable Federal criminal law against promoters of MEWA's as fiduciaries to plans, these actions are considerably different from and often more limited than those generally available to the States under their insurance laws.

The States also have the expertise necessary to assess whether MEWA's have adequate liquidity and to determine, among other things, the proper levels of sales commissions and administrative expenses associated with insurance underwriting.

Because the State insurance laws have substantive requirements for such items as funding, reserves and qualifications for operating an insurance company and selling insurance products, they can stop unscrupulous promoters by obtaining and enforcing cease and desist orders to prevent them from operating MEWA's in the first instance.

Having addressed the State's authority to regulate MEWA's, I would now like to discuss the Department's responsibility for MEWA's under Title I of ERISA. Very few MEWA's are themselves employee welfare benefit plans within the meaning of that term under ERISA. MEWA's are, therefore, generally not directly subject to Title I of ERISA.

However, even if the MEWA itself is not a covered plan, each employer or employee organization which utilizes the MEWA's to provide health benefits for its employees or members would be considered to have established and maintain a separate single-employer plan, subject to ERISA's provisions. Where a MEWA holds assets of such plans, the promoters receiving, managing and disposing of these assets are fiduciaries under ERISA and subject to the Department's investigative and enforcement authority, including, where the facts warrant, criminal proceedings.

The Department will insure that MEWA's are properly operated in accordance with applicable ERISA requirements. Furthermore, the Department is committed to providing the States with all the information and support necessary to regulate MEWA activity over which they have jurisdiction.

The Department maintains an active enforcement program to assure that fiduciary and other responsibilities under ERISA, including those relating to self-funded welfare plans, are met. The Pension and Welfare Benefit Administration, the PWBA, is currently conducting approximately 40 civil and criminal MEWA-related investigations. One of these cases is currently being litigated in the U.S. District Court.

MEWA cases will continue to be a priority under our significant issues enforcement strategy.

The Department has recently begun extensive efforts to enhance communications and to share information with the State insurance agencies regarding MEWA's. In my letter dated January 31, 1990, to Congressman William Hughes, Acting Chairman of the Subcommittee on Retirement and Employment, I describe in detail the coordination efforts being undertaken between various PWBA field offices and the States regarding MEWA's.

The Department has also exchanged letters with Earl Pomeroy, President of the National Association of Insurance Commissioners, NAIC, which details these efforts. The NAIC's response has been positive, and I ask that these letters be included in the record.[1]

Senator NUNN. Without objection.

Mr. BALL. The Department's various field office activities include regular MEWA meetings between PWBA field offices and the State insurance commissioner staffs, joint participation in enforcement committees designed to share information and conduct joint investigations, and the presentation by PWBA of training sessions on ERISA to staff of the State insurance commissioners. In addition, I have directed all PWBA's field offices to have all disclosable portions of their investigations available to the States, upon request.

An example of this coordination activity has been demonstrated by PWBA's Boston Area office. This office is currently investigating a MEWA and its successor MEWA. The original MEWA is insolvent. It has accumulated unpaid claims of approximately $5 million, with assets of less than $100,000. The successor MEWA is marketed, as underwritten, by an insurer which provides insurance and reinsurance service to MEWA's located in many different States.

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[1] See Exhibit No. 40 on p. 394.

In April of this year, the Boston office wrote to 33 different State insurance Departments, in order to provide them information about its investigation of these MEWA's. These States are those in which the insurer has a certificate of authority to write insurance and those in which employers who subscribe to the original MEWA are located. The Boston area office's letters also provided the States with a list of the MEWA's which the insurer services and notified the States that it stands ready to assist them in any way possible.

As a result of this activity, the following actions have occurred: The State of Georgia intends to issue a cease and desist order to the insurer, barring it from writing insurance business in that State.

The State of Massachusetts has notified the insurer, which is not licensed or authorized to conduct insurance business in the State, to cease and desist from engaging in any insurance activities in the State, unless it complies with Massachusetts laws. The State emphasized that the insurer is required to comply with all existing contractual obligations, including payment of any claims. The State of Massachusetts has also issued a cease and desist letter barring the provision of any unauthorized insurance business by the original MEWA's former contract administrator.

The State of North Carolina is actively involved in the investigation of the original MEWA. Thirty-six of the contributing employers to the MEWA having unpaid claims are located in the State. North Carolina had issued a cease and desist directive to the insurer in April 1989, directing the insurer to immediately suspend the writing of any further business in the State.

In an effort to further assist the States, the Department has recently undertaken a number of initiatives which I would now like to discuss. These initiatives consists of a six-point program to assist the States in dealing with MEWA issues.

Yesterday, Secretary Dole wrote to the State insurance commissioners, outlining these initiatives and trying to establish a more effective working partnership with the States. I ask that this letter be included in the record.[1]

Senator NUNN. Without objection.

Mr. BALL. The six-point program for aiding the States is as follows: One, we are preparing technical assistance materials for the staffs of State agencies. These materials will explain the department's and the States' role with respect to MEWA's and ERISA in plain English.

Two, we are exploring with the National Association of Insurance Commissioners the possibility of conducting regional conferences and training sessions on MEWA's and ERISA for the staff of interested State and Federal agencies. These conferences would be conducted by PWBA independently or in conjunction with other Federal and State agencies and the NAIC.

Three, we are pursuing cooperative arrangements with appropriate State agencies under which PWBA's regional area offices will share and discuss cases open and closed by PWBA involving

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[1] See Exhibit No. 35 on p. 378.

MEWA's. They will make available documents obtained through voluntary production or civil subpoenas.

Four, we are providing expedited review of advisory opinion requests from States on the issue of whether a particular entity is a MEWA for purposes of the exception to ERISA preemption of State regulation. These opinions are often critical to States as they proceed with their enforcement efforts.

Five, we are distributing copies of all advisory opinions concerning MEWA's to the insurance commissioners of each State on a quarterly basis.

Six, we are reviewing the Form 5500 annual report filed by employee benefit plans under ERISA and the ERISA computer data base system, to determine whether it is possible to identify MEWA's through the annual reporting process. Our preliminary review indicates that such identification will generally not be possible. However, to the extent that such identification is practicable, we will provide a listing of the identified MEWA's to the States.

We believe these initiatives should make a significant contribution to the formulation of a more cooperative and effective State and Federal strategy for dealing with MEWA's. As I previously indicated, we have met with the President of the NAIC and are encouraged by his support of the initiatives.

In March of this year, Secretary Dole recommended legislation that would require MEWA's to file registration statements with the Department. Willful failure to file such statements would be subject ot the criminal sanctions of section 501 of ERISA.

This proposal, we believe, will provide significant assistance to State insurance departments in policing these trusts by providing a national registry of information about MEWA's and the persons who operate them and should enable the States to act early to prevent situations where contributions and reserves are inadequate to meet benefit claims. It should also benefit small employers and their employees who are the victims of unscrupulous promoters of MEWA's.

The Secretary has also proposed a major budget increase in ERISA enforcement and legal staff. The Department's request of 133 new positions dedicated to ERISA enforcement will generate 1,000 new investigations annually in both the pension and welfare plan areas.

Senator NUNN. Mr. Ball, is that part of the President's budget?

Mr. BALL. It is part of the current budget request.

Senator NUNN. It is part of the President's budget?

Mr. BALL. Yes, sir.

Senator NUNN. OK. Thank you.

Mr. BALL. With this enhancement, we will be in a better position to devote the resources necessary to deal with this apparently growing problem.

In conclusion, we regard the MEWA situation as an important one. However, in all candor, Mr. Chairman, I must tell you that neither we nor anyone else has an accurate picture of the scope of the PWBA problem.

Senator NUNN. So, what you are saying there—I think that is a very important sentence—is that nobody knows how much of a problem we have in this area?

Mr. BALL. Yes, sir, that is correct.

Senator NUNN. The States have said they do not know and you said you do not know.

Mr. BALL. That is correct, sir.

Senator NUNN. How did we get into this situation? This has been going on a long time. We had amendments trying to correct this problem way back in 1982. The Department has taken—the first legislative recommendation you made, really, is in March of this year. Is not the Labor Department supposed to look and give oversight to these situations in a general broad sense and alert the Congress and alert other people, including the States, when there is a problem?

Mr. BALL. Well that is exactly what has happened, Mr. Chairman, under Secretary Dole. When she came into office, she began enforcement review and part of that enforcement review identified this area as a problem area.

Senator NUNN. What happened before Ms. Dole got there? The Labor Department has been there a long time.

Mr. BALL. I do not think that there was the same degree of activity in this area as there is currently. Currently, under Secretary Dole——

Senator NUNN. There is always going to be fraud and abuse, there is no way you can keep fraud and abuse out of any system. I am not saying that any Department can do that, nobody can. This is the largest series of gaps in coverage that I know anything about.

I mean it is one big gap after another that are not little trifling gaps, they are very big gaps in the law and we have heard this morning. You are saying it here today in your own statement. How can we have these kinds of things go on this long, after looking at the gaps in 1982, and have nothing happen, no leadership from the Department of Labor until March of this year?

Mr. BALL. I think part of the reason, Mr. Chairman, for the growing attention in this area is the escalating costs of health care. The attention that has been paid to this area is much greater today than it was ever before, because there is enormous concern about the cost of health care.

Senator NUNN. So, basically, you are saying, Mr. Ball, that you really cannot tell us this morning how many Americans out there, men and women who believe they are insured, really do not have any insurance, because the companies they are involved in are not even known to the Department of Labor or to the States, and many of them we are not going to know the problems until the claims simply cannot be paid. Is that what you are saying?

Mr. BALL. Yes, sir, I am saying that neither we nor anyone else has an accurate picture of the scope of the MEWA problem.

Senator NUNN. OK.

Mr. BALL. We believe that requiring all MEWA's to file registration statements with the Department will enable both the Department and the States to get a handle on the number and location of these entities. If the Department's proposed legislation is enacted, it should be a significant help to the States seeking to assure that MEWA's comply with their insurance laws.

We believe that both the Labor Department and the States have important roles to play in protecting persons who purchase health coverage from MEWA's. We believe that the Department's recent initiatives will be of significant assistance to the States. The Department has made MEWA enforcement a priority and will do all it can to assure that ERISA's requirements are followed.

That concludes my prepared statement. I would be pleased to answer any questions that you or other members of the committee may have.

Senator NUNN. Thank you, Mr. Ball. We will come back with questions.

Let me hear from the other two witnesses first, I guess Mr. Moody and then we will have Mr. Maria clean up here.

## TESTIMONY OF JIM E. MOODY, SECTION CHIEF, ORGANIZED CRIME SECTION, CRIMINAL INVESTIGATIVE DIVISION, FEDERAL BUREAU OF INVESTIGATION [1]

Mr. MOODY. Thank you, Mr. Chairman.

My name is Jim Moody. I am the Chief of the Organized Crime Section at FBI Headquarters.

Mr. Chairman and members of the Subcommittee, I am pleased today to have this opportunity to appear before you and provide testimony.

On April 11, 1988, this Subcommittee received the testimony of Director Sessions, which detailed our investigative strategy and successful investigation of the La Costa Nostra or the LCN over the last 25 years. On April 12, 1989, Floyd I. Clark, then Executive Assistant Director and now Deputy Director of the Federal Bureau of Investigation, addressed this subcommittee on the FBI's policies, strategies and progress against organized crime, as well as FBI investigation and use of civil remedies as provided by the Racketeer Influenced and Corrupt Organizations statute, the RICO statute.

We believe the FBI has achieved unprecedented success in the war against organized crime. These successes led to the development and implementation of an organized crime national strategy and fully utilized the enterprise theory of investigation. Nationwide management of the FBI's organized crime program requires adherence to that strategy and constant reevaluation of investigative priorities and resource allocations to accomplish its goals and objectives.

Without such oversight, current resources dedicated to the investigation of organized crime would not have brought the commission of the LCN to justice, nor would the FBI's major prosecutions of LCN families nationwide have been accomplished.

Labor racketeering violations as committed by organized crime groups occupy the highest priority within our national strategy. As a result, many of our expansive investigations and subsequent prosecutions of organized crime enterprises are based, in part, upon labor racketeering predicates, including violations of Title 18, United States Code, relating to the Employee Retirement Income security Act of 1974 or ERISA.

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[1] See p. 161 for Mr. Moody's prepared statement.

The massive civil RICO complaint against the General Executive Board of International Brotherhood of Teamsters, the Commission of the LCN and numerous LCN members and associates nationwide was based upon information gleaned from 213 criminal investigations of LCN members and associates involved in labor racketeering activities.

On February 6, 1990, 20 members and associates of the violent street crew of the former Chicago LCN boss Joseph Ferriola were indicted. On March 22, 1990, the hierarchy of the Patriarca LCN family was indicted in Boston, Providence and New Haven. The Patriarca indictment is partially comprised of labor racketeering matters and, although the Ferriola indictment does not contain a labor racketeering predicate, the prosecution will have a significant impact on an organization that is heavily involved in labor racketeering.

Now, this Subcommittee received testimony from Director Sessions detailing many far-reaching prosecutions of major LCN families, the predicate bases of which were labor racketeering violations. Current initiatives suggest a continued, steady progress in our mission, as stated in our national strategy, "to remove the LCN as a significant threat to American society."

The FBI and the Department of Labor have concurrent investigative jurisdiction over criminal violations of ERISA and selected labor-related violations of Title 18 and Title 29, United States Code, applicable to the multiple-employer welfare arrangements or MEWA's.

It should be noted that a MEWA is an employee welfare arrangement established or maintained by two or more employers for the benefit of their employees, in which the subscribing employers have no common relationship such as that derived from a common control group or participation in a collective bargaining agreement. In other words, employees are not represented by a labor union and the "welfare arrangement" is provided by the employer as a benefit of employment, not as a labor-management contractually bargained obligation.

Although most MEWA's are not regarded as employee benefit plans themselves, those arrangements frequently provide health and other welfare benefits for small employers who, by their financial subscription to the MEWA program, establish benefit plans for their employees which are subject to Federal regulation under ERISA.

The FBI and the Department of Labor concurrent jurisdiction over MEWA's is derived from statutory delegation, as well as by memoranda of understanding. The FBI's intelligence base does not indicate that MEWA's have been solely or selectively targeted by organized crime groups.

However, industry service providers, such as third-party administrators or labor consultants who service numerous employee benefit arrangements which may include MEWA's, have brokered illegal business transactions and/or fraudulent schemes that have been investigated by the FBI and have been prosecuted for their involvement with organized crime members as part of the racketeering enterprise.

For example, the nationwide joint FBI-Office of Labor Racketeering investigation code-named DENTEX, we believe, demonstrates LCN control and influence over the operations of 12 health and welfare plans in seven cities. Criminal violations relating to ERISA-covered plans, mail fraud, fraud by wire and conspiracy serve as predicated bases for racketeering indictments of the plan administrators.

The top investigative priority of our organized crime national strategy is the "detection of organized crime influence, infiltration, control of domination of legitimate businesses and/or labor unions in our society and the eradication of that presence."

To achieve that objective, all complaints or allegations received by the FBI which pertain to labor-related violations are reviewed and evaluated with respect to the involvement of organized crime and current prosecutive guidelines. Complaints which are apparent ERISA matters fall within the responsibilities of the organized crime program. When the organized crime element is not present and/or the minimum prosecutive criteria for ERISA matters are not met, the complaint or allegation is forwarded to the Department of Labor, in accordance with our memoranda of understanding, for their regulatory and investigative consideration. This case administration is necessary, for the efficient use of organized crime program resources.

Senator NUNN. Mr. Moody, could I get you to summarize, if you could? We will put your whole statement in the record. I want to get to Mr. Maria and ask him to do the same thing, if he would, so we can have time for questions.

Mr. MOODY. OK.

We also investigate MEWA's in our white collar crime program, primarily involving fraud cases, mail fraud, wire fraud, and various banking and security fraud statutes. We found that the majority of investigations like this may include multiple violations of Title 18 and Title 29.

With the 269 investigative and administrative classifications of statutory law which provide the FBI with the sole or primary and/or concurrent jurisdiction with other agencies, the overlapping and concurrent responsibilities we have set up in various memoranda of understanding with all the other agencies to avoid duplicative or wasteful usage of investigative resources. We emphasize the need for our personnel to live by these memoranda of understanding.

Now, the Department of Labor is charged with very broad regulatory enforcement responsibility for ERISA. Our memoranda of understanding between the FBI and the Office of Inspector General assure coordination of ERISA matters with the Department of Labor and allow the FBI to maintain our national organized crime program.

I have been asked for some statistics concerning MEWA's. It is extremely difficult for the FBI to provide that, because we do not keep statistics based upon individual MEWA but upon individuals and the violations for which they were convicted.

We have had some very successful cases on MEWA's, including the massive RICO investigation and subsequent convictions of Mario Renda doing business as the First Fund in New York. He skimmed interest payments rightfully belonging to unions and paid kickbacks to union officials for his initial placement of certificates of deposits in major banks.

If I may summarize, the identification of a business structure like a MEWA is of statistical interest to an agency such as the Department of Labor, with regulatory responsibilities over that entity. In the event that a crime problem outstrips a regulatory mechanism, local remedies to the problem must be sought within parameters established by the investigative and regulatory agencies.

The FBI and investigative agencies without regulatory perspective on this issue are not aware of any quantitative or qualitative analysis of the crime problem in this area. As previously stated, our intelligence base does not indicate that MEWA's have been solely or selectively targeted by organized crime.

We maintain that the standards set for us through our national strategy and through the coordination with the U.S. attorneys' offices to insure prosecutive priorities are met, that we are addressing those identified criminal MEWA's that are influenced by organized crime and/or some MEWA's that may be involved in other Federal violations.

This concludes my statement. Thank you.

Senator NUNN. Thank you very much, Mr. Moody.

You are basically saying that the programmatic side of this, the regulatory side of it, the statistical, the quantitative and qualitative analysis has got to come from the agency involved, that the FBI does not look at these problems that way, is that right?

Mr. MOODY. That is correct, sir.

Senator NUNN. And that has to be the Labor Department?

Mr. MOODY. Yes, sir.

Senator NUNN. Thank you.

Mr. Maria.

## TESTIMONY OF RAYMOND MARIA, ACTING INSPECTOR GENERAL, U.S. DEPARTMENT OF LABOR

Mr. MARIA. I will submit my full statement for the record[1] and would like to summarize, if possible.

Senator NUNN. OK.

Mr. MARIA. Mr. Chairman, this morning we have heard lurid tales of fraud and victim tragedies. I am not talking about technical or accidental violations, but about fraud in bold capital letters, indeed the second oldest profession in the world, and there are many among us here today who think that fraud—malicious, purposeful, wanton fraud—can be addressed through civil remedies.

What will punish fraud is the criminal remedy. We heard testimony today that fraudulent MEWA's, producing the victims such as we have seen today, these fraudulent MEWA's split and multiply like cancerous cells, if you will indulge a medical metaphor.

In the criminal investigative process, we are surgeons, we do not treat cancer with an aspirin such as a civil remedy, we excise it with a scalpel. What I am talking about is a criminal investigation leading to jail and forfeiture of assets and disqualification from benefit plan positions for 13 years.

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[1] See p. 171.

Now this Subcommittee's interest and its efforts were primarily responsible for the Comprehensive Crime Control Act of 1984, which included a provision that amended ERISA. That amendment to ERISA practically demanded that the Secretary of Labor increase the Department's criminal investigation in the area of employee benefit plans. Unfortunately, the Secretary has not heeded the intentions of Congress.

In fact, it is clear that, with the exception of the Office of Inspector General, very little, if anything, has changed at the Department of Labor with regard to criminal enforcement in all the years in which this subcommittee has maintained an interest in this area.

Senator NUNN. Is that provision of law simply being ignored?

Mr. MARIA. We are dealing with what I have testified to these many months as a flawed enforcement strategy. You inquired of the Assistant Secretary earlier what prompted the Secretary's enforcement review. Might I remind everyone that that review was a response to the Inspector General's earlier criticism of a year ago of the flawed enforcement strategy, one which places an undue reliance on civil and administrative remedies, and indeed ignores the fact that you are dealing in many areas, certainly in the area of employee benefit plan abuse, fraudulent, self-funded MEWA's, with professional racketeers and criminals who are not deterred by fines. Fines are a cost of doing business.

Senator NUNN. Our State witnesses this morning from the various State insurance departments basically said that what they needed was less Federal involvement in the regulatory part of MEWA's and more Federal involvement in the criminal side of it. Is that generally what you are saying, too?

Mr. MARIA. I would categorically endorse that.

Senator NUNN. Mr. Ball, what do you say about that?

Mr. BALL. The enforcement strategy that we have, Mr. Chairman, is similar to other Federal regulatory agencies. We pursue investigations where we believe there are violations of ERISA. We do not begin civil investigations, we do not begin criminal investigations. We begin investigations, period, and when those investigations lead us to identify a criminal matter, then we work with the U.S. Attorney and conduct a criminal investigation.

The results that we have achieved are very similar to other comparable agencies. For example, the Department of Labor regulates pensions. The Securities and Exchange Commission regulates securities. The Securities and Exchange Commission does not have criminal investigators and neither does the Department of Labor. The Securities and Exchange Commission starts in the same way that we do. They conduct investigations and when they identify a criminal matter, they work with the U.S. Attorney.

I would submit, Mr. Chairman, that our results are similar to those of the SEC. The SEC has a very high reputation for integrity and effectiveness in its enforcement strategy. Our strategy is very similar and our results are very similar, if you allow for the fact that they have three times as large a budget and three times as large an enforcement staff. The ratio of criminal actions to civil is roughly the same.

Senator NUNN. Mr. Maria, what do you say about that? I will go ahead and let you finish your statement, then.

Mr. MARIA. I would like to come back to that question but, if possible, finish my summary.

Senator NUNN. All right.

Mr. MARIA. People committing MEWA related fraud are professional thieves, people for whom, again, civil fines are merely a cost of doing business. They move from one MEWA to another, indeed from State to State. These are people who have experience in penny stock frauds and other boiler room sales operations. Indeed, these are the people that can be traced back to the primer on white-collar crime, The Fountain Pen Conspiracy, and we presently have one of those individuals under investigation today.

Now, in responding to calls for criminal enforcement—I emphasize that word, criminal enforcement—the Inspector General has one hand tied behind his back today, because of this opinion from the Department of Justice which truly restricts the investigative activity of the Office of Investigations. It does not affect our Office of Labor Racketeering, but it does affect our Office of Investigations.

We have heard that MEWA fraud is not a new problem. The States have testified that they brought this problem to Congress' attention in 1982. We are here some 8 years later, and since that time how many criminal indictments of MEWA operators have been returned that have resulted from PWBA investigations? I am not aware of any.

The Pension Welfare Benefits Administration, under its enforcement strategy, believes that ERISA is primarily a civil statute, where penalties should be limited to restitution and what amounts to a promise not to do it again. This position, as we have mentioned in the Office of Inspector General, is just plain bad government policy. Only criminal remedies can punish criminal conduct, and with the imposition of Federal sentencing guidelines, today jail is a real possibility for those who commit benefit plan fraud.

Even if the Pension Welfare Benefits Administration wanted to change its civil emphasis, it does not have, unlike the Office of Inspector General, any professionally trained and federally recognized criminal investigators; people who know where to look and how to look, special agents that are adept at using standard investigative techniques such as the use of informants, the use of electronic surveillance, physical surveillance, search warrants and undercover operations. I submit that it is precisely those techniques that will gather compelling evidence against professional racketeers.

With a policy that relies inordinately on civil redress and a staff which has no professional criminal investigators, I submit that the Pension Welfare Benefits Administration institutionally is incapable of recognizing flagrant fact patterns and conceptualizing all potential criminal offenses which may be relevant to a case.

A classic example of this deficiency occurred when the Secretary of Labor, following a PW investigation, recently filed a civil suit in Texas against the administrator of a chemical suppliers pension plan. I think the case is instructive in point. We are still dealing with employee benefit plans and we are dealing with what my office contends is a flawed enforcement strategy, one that does not recognize flagrant criminality.

Their press release on this suit alleges a conflict of interest by an administrator when he took $1 million in pension plan money in the form of loans to himself and a business partner, lent the pension funds to others to invest in businesses in which he had an interest. As a result of these loans, the administrator, according to their press release, concentrated the plan assets in cattle investment programs, in violation of ERISA's diversification rules. The thrust of this is that they are saying there is a conflict of interest and that the subject, the defendant in this case has violated prudent investment transactions, he has failed to diversify his investment portfolio.

Senator NUNN. What you are saying is he stole the money?

Mr. MARIA. Well, it gets worse than that. The dollar amounts in this case and the basic fact pattern in this press release cry out for criminal investigation; but PWBA, and indeed, the Solicitor's Office, have failed to recognize, let alone aggressively pursue, this avenue. After meeting with the U.S. attorney in Houston, the Inspector General has begun an investigation of this matter. Our initial allegations and the initial information stand in stark contrast to what the PWBA press release represents.

We have received allegations that the administrator and his mistress or business partner illegally diverted not $1 million, but between $2 and $3 million of plan money. They used forged loan documents to finance a cattle operation at their ranch. The loan allegedly was unsecured, the cattle were sold, and the money is gone.

Parenthetically, I should note that this individual also is the subject of allegations that he maintains an illegal toxic waste dump on the ranch. We have also learned that these pension plans were defined-contribution plans and, therefore, not insured by the Pension Benefit Guarantee Corporation, that false documents were provided to plan participants, and that false 5500 forms were submitted to the Department of Labor and the Internal Revenue Service.

This, I think, illustrates the folly of relying on 5500 forms to generate leads related to significant criminal activity. A basic statement in life—crooks do not file truthful forms.

We have all the indicia of flagrant fraud, deceit and concealment, acts which clearly go over the line from imprudent business transactions or conflicts of interest. You have an embezzlement to purchase cattle, the cattle are gone, the money has gone south. You have plan participants asking "where's the beef," and from PWBA all it gets is a lot of "bull" today.

This Subcommittee has long employed the Department of Labor for years to employ criminal remedies against those who would defraud American workers. For labor racketeering matters, this Subcommittee has made sure that a labor racketeering function was established in the Inspector General and the I.G. Act was passed in 1978. That is to ensure an objective, independent criminal investigative function for labor racketeering matters. I believe the Office of Labor Racketeering has carried out this function with distinction, contributing over 750 convictions over the past 12 years, including over 300 benefit plan related convictions.

Thus far, the Office of Labor Racketeering, through its investigation, has obtained one criminal indictment in Atlanta, Georgia, involving four individuals and two corporations operating a fraudulent MEWA. We presently have 24 fraudulent MEWA investigations in progress. The MEWA investigation in Atlanta and the indictment involves some 9,000 employees and dependents, nearly 300 companies doing business in 16 different States, and at the time of the investigation there were medical claims that were unpaid in excess of $800,000.

Secretary Ball, in his statement, I think, has made it clear that fraudulent MEWA's are basically a State, rather than a Federal problem, since the States normally regulate insurance operations and they virtually in all instances are not restricted by ERISA's preemption rules. This may be true in theory, but it falls short in practice.

How can the State of Georgia recover premiums or institute criminal proceedings when MEWA operators in Atlanta have moved to North Carolina, California, New York, and indeed even to Europe? How can a cease and desist order, how can a judgment be effective, when it cannot be served, when the individuals are not in your State? How can restitution be obtained when premiums have already been spent by MEWA operators and the money is diverted out of State for the big ticket items that you heard described?

Civil enforcement strategy is inherently flawed when it comes to dealing with criminality. What we need is aggressive criminal enforcement. There are more indictments forthcoming from Office of Labor Racketeering Investigations, as I continue to detail some special agents from the Office of Investigations to the Office of Labor Racketeering precisely to pursue flagrant MEWA fraud.

More could be done if it were not for this Department of Justice opinion which has been supported by the Secretary of Labor, and was requested by the former Solicitor of Labor. If it were not for this opinion, I could double and, indeed, triple the number of criminal investigations against self-funded MEWA's today.

I strongly urge all the members of this Subcommittee to support legislation which has been introduced by Senator Glenn and cosponsored by many members of this Subcommittee which would clarify the investigative authority of the Inspector General and nullify the effects of the Department of Justice's opinion. An identical bill has been introduced in the House by Representative Conte.

People are entitled to protection. The victims that you see here today require some type of retribution. We are not talking about the employees of Fortune 500 companies. We are talking about people who are employed by small companies, people who tend to be—you have heard the salary statements—from the low end of the socioeconomic spectrum. They need all the benefit protection that the Government can afford them. They should not be the victims of fraud.

Thank you.

Senator NUNN. Thank you, Mr. Maria.

Let me just ask one broad question before we get down to the particulars. We have been involved in this subcommittee for a long time looking at pension fraud, looking at all the traditional organized crime involvement in the pension funds, mainly funds run by union-management and so forth.

What we are hearing here today and what we have heard I think in the past several years is that this area is no longer involved strictly in the organized crime-pension fund-labor union trustee methodology.

What we are seeing is that this area of fraud covers an awful lot of what would be known as white collar fraud. You have accountants, you have lawyers, you have insurance salesmen, you have bankers, you have benefit plan administrators, all of those people are now, in effect, in some capacity involved in this and in many cases they are the ones who are indeed the racketeers, is that correct?

Mr. MARIA. That is correct, Senator Nunn. The Teamsters and the organized crime element do not have an exclusive monopoly on racketeering and racketeering within the benefit plan arena clearly extends to the white-collar individuals that you have described. Their acts are as malicious and destructive as those committed by any Mafia figure.

Senator NUNN. Well I congratulate the IG's office in recognizing that and taking steps in this respect, and I can assure you, we will be listening to your recommendations very carefully.

I want to ask a number of questions here. Senator Roth, I will be glad to defer to you at this point and then come back.

Senator ROTH. Thank you, Mr. Chairman.

Let me make an observation. It seems to me that there are two questions before the Subcommittee at this time: One is what needs to be done to properly enforce the laws on the books, and I have to say that, in that regard, after listening to the testimony today, there seems to be substantial reason for more criminal investigation, with that I agree.

On the second question, as to who should conduct these criminal investigations, I think there is another question. I, for one, at least at this stage am not persuaded that that necessarily should be done by the IG. I think one of the primary purposes in creating the IG was to have an independent body investigate the adequacy of the agency itself, and I think this is a decision for Congress, Mr. Chairman, one that ought to be looked at with great care.

If we are going to delegate that responsibility to the IG's not only of this agency but of everyone, in effect, saying that they have the freedom to investigate criminal investigations as they see fit, then I think we have a question of who is going to audit their actions. In other words, as both you and I were very much involved in the creation of the Inspectors General, it was my belief that they were an independent body to review, to audit and, on occasion, make a criminal investigation to determine the adequacy of that agency.

But if we are going, as I understand your testimony, to delegate the responsibility of making criminal investigations to the IG, then I think we are undercutting one of the purposes of the IG itself. I am not going to come to any final conclusions, but I have some very, very serious doubts about delegating that power to the IG. I think that is something that should be determined by the Congress.

I fear it is becoming, to be perfectly candid, a turf war, with people seeking additional jurisdiction, and I think the final analysis ought to be where we think it will best serve the administration of the laws.

Thank you, Mr. Chairman.

Senator NUNN. Thank you, Senator Roth.

Let me ask you, Mr. Maria, the question that I interjected a few minutes ago. Mr. Ball cites that the SEC has as very similar statistical pattern in relationship between civil and criminal, and that the Labor Department basically in these areas that you covered is in a similar position, and that the SEC has a very good reputation. What is wrong with Labor following that pattern? Do you want to respond to that?

Mr. MARIA. Well, I think it is a question of apples and oranges. Not to be critical of the SEC, but let us look at what they enforce. They are enforcing laws with respect to the sale and purchase of securities. We are talking about optional investments of assets, securities, stocks, bonds, commodities, things of this nature. That is not what these witnesses testified to here today. They are talking about the purchase of something very basic and very fundamental: health care. They do not want to be in the hospital, because if they are there, they will not be able to afford it.

I submit, we are dealing with fraud that is more pernicious and more malevolent, because it affects people at the low end of the scale, not people who are buying stocks and bonds, but people down earning $20,000 a year who are only interested in being able to pay their medical bills and not having their small possessions, indeed, their nominal possessions attached.

Senator NUNN. You are saying that in this case, the Labor Department's authority and responsibility goes further in the sense that they are protecting the people that, without government, cannot protect themselves in these areas, is that right?

Mr. MARIA. Absolutely.

Senator NUNN. Mr. Ball, do you want to respond to that?

Mr. BALL. Well, of course, Mr. Chairman, there is no perfect analogy to what constitutes the responsibilities of the Labor Department, but the purpose of my analogy with the SEC was to draw a comparison with regard to the enforcement effort and with regard to the allocation of enforcement resources between civil prosecution and criminal prosecution.

In the pension area, for example, Mr. Chairman, it really is very important to restore the plan assets to the participants. We pay a great deal of attention to trying to put criminals in jail, but it does not do any good for the pension plan participants who have been defrauded, if you only send those people to jail. You have to try and get the money back. During the last 5 years, the Department of Labor has recovered $480 million for pension plan participants.

Senator NUNN. What about in the health area? We heard these victims this morning. What is the Labor Department's policy in trying to get their insurance claims covered, and all those out there that are not covered that think they are?

Mr. **Ball**. There is a completely different regulatory pattern with regard to MEWA's than there is with regard to pensions. The statutory structure is very different. The Department of Labor does not have the authority to regulate the funding or contributions to health care plans like MEWA's. We do not have jurisdiction over that. We have less jurisdiction with regard to MEWA's than we do with pensions.

Senator **Nunn**. You heard the testimony this morning of State insurance commissioners, and basically they were testifying that they would like to see the Department of Labor get out of the regulatory part of these MEWA's altogether and leave it up to the States, so there would be a clear line of authority, but get much more involved in the criminal end of it, both the Labor Department and the Justice Department. What do you say to that suggestion or those suggestions?

Mr. **Ball**. Our view, Mr. Chairman, is that we should establish an effective working partnership with the States and, indeed, with other government agencies in prosecuting criminal activity, and we are doing that.

One of the things that really has not been brought out, and I think it is really important to be brought out, is that there has been a significant change in the enforcement effort under Secretary Dole. Secretary Dole has made a legislative initiative that is trying to enlist the participants, and as the IG recommends, to get accountants involved in the enforcement effort. Secretary Dole has also asked for a 33 percent increase in the enforcement staff, which is very significant.

Finally, Mr. Chairman, perhaps most importantly, I would like to read to you the statistical results of criminal enforcement over the last 4 years: In fiscal year 1987, PWBA opened 16 criminal investigations; in 1988, 23 criminal investigations; in 1989, 31 criminal investigations. This year, to date, we have opened 68 criminal investigations. We have more criminal investigations ongoing now than we have ever had in our history.

The same is true, Mr. Chairman, with regard to MEWA's. We have at this moment 40 civil and criminal investigations of MEWA's going on. This is more than at any time in our history.

Senator **Nunn**. How many of those are civil and how many of them are criminal?

Mr. **Ball**. As I mentioned before, Mr. Chairman, we do not open our cases as civil or criminal. We open them as investigations and we pursue them wherever they may lead.

Senator **Nunn**. I understand that.

Mr. **Ball**. At this point, 7 of those 40 are criminal, but it is very likely that others of those 40 will become criminal. This compares with the number that the Acting Inspector General used, he has 24 ongoing at this moment. If you combine the two together, that is the highest enforcement effort by the Federal Government of criminal activity with regard to MEWA's at any time in the history of the United States.

Senator **Nunn**. I am informed on the overall numbers you just gave—and maybe these are correct and maybe they are not, and maybe you could check them—that in 1985, you had a total field investigations processed of 1,675, and 35 of those were criminal, 2 percent; in 1986, there were 1,687 field investigations processed, 47 of them were criminal, 2.7 percent; in 1987, 1,758 processed, 25 of them were criminal, 1.4 percent; in 1988, 1,610, and 23 were criminal, 1.4 percent; fiscal year 1989, 1,581, 28 were criminal, thereby giving a 1.8 percent. So, I do not see any noticeable trend percentage-wise of increase in criminal activity.

Mr. BALL. Mr. Chairman, I would like to add to your statistics the results that I just cited for the open investigations. We have 68 criminal investigations ongoing at the moment, that is more than at any time in the history of the department.

Senator NUNN. What is the percentage, though? What is the percentage?

Mr. BALL. It undoubtedly is a higher percentage than any of those percentages that you just cited. I do not know the exact percentage.

Senator NUNN. How many professionally trained criminal investigators does PWBA have on the staff?

Mr. BALL. Like the SEC, Mr. Chairman, we have none. We are just like the SEC, we pursue investigations and we work with the U.S. attorney and, in turn, we have available to us the resources of the FBI and other government agencies in pursuing criminal investigations.

Senator NUNN. When you get to the point where they recognize it as being criminal—but in the nature of this Labor enforcement, I have been looking at this a long time—it takes an enormous amount of investigation before you ever get it to the point of turning it over to the Justice Department and the FBI. If you do not have anybody along this line, thinking in terms of criminal investigation as you go along, then you are not going to have very much results from it, it is just that simple. That has been the case for 15 years, it apparently has been the case for 15 years. This subcommittee has tried to do something about it. We have done everything, including passing a law and still it is ignored.

Mr. Moody has just testified and it is very clear from all the FBI testimony we have ever had, that they have to rely on the Labor Department to basically deliver them a prima facie almost case before they can get that much involved in this—too many of them. So they are relying on you and you do not have any criminal investigators, nobody professionally trained, right? No plans to hire them?

Mr. BALL. Mr. Chairman, we believe that our enforcement strategy is effective. We believe that, just like the SEC who also has no criminal investigators, that we are able to pursue the matter. ERISA is a very, very complicated statute, which requires sophistication and training to understand.

I would like to add, however, that we have, again under Secretary Dole, an initiative with regard to training in criminal matters. Next month, we will begin our own first formal training program, criminal training program at the University of Colorado, at Boulder.

Senator NUNN. You are going to train some of your own people there?

Mr. BALL. Yes, sir, we are. We also send our people to the Federal Crime Program in Glynco, GA.

Senator NUNN. You are then acknowledging that all these years we have been arguing that you should been doing that, is that right?

Mr. BALL. Yes, sir, and what I am saying is that since Secretary Dole came to office, we have stepped up our training and our enforcement effort and our criminal prosecutions.

Senator NUNN. Well, I am delighted to hear that. I hope you will keep us informed of that.

Mr. Moody?

Mr. MOODY. Let me correct one possible misconception. We are a little bit more pro-active than waiting for cases——

Senator NUNN. Prima facie case may have been a little strong, but I have noted over the years that the FBI does not rely on the Labor Department to furnish you a great deal.

Mr. MOODY. Not always. We have a lot of joint investigations going on right now with the Department of Labor in various aspects, all sorts of investigations. In fact, recently I was sitting down just looking at the number of other agents or police officers or investigators from other departments working in the organized crime program, and we basically increase our total manpower by in excess of 20 percent on a day-to-day basis.

Senator NUNN. Mr. Moody, are you working those cases with the IG or with PWBA?

Mr. MOODY. We are working the one in Atlanta with IG, the one that you heard about today, the pending investigation with the IG.

Mr. BALL. They are also working cases with PWBA.

Mr. MOODY. And I believe PWBA.

Senator NUNN. You are not sure about PWBA?

Mr. MOODY. We work with everybody, Senator. [Laughter.]

Quite frankly, if I went out and was making inquiries about cooperative endeavors, it may have a dampening effect on the agents as if I did not want it to happen, so I do not do it. I encourage it through all of our training programs.

Senator NUNN. Mr. Ball, you stated that Secretary Dole has proposed legislation that would require MEWA's to file registration statements with the Department of Labor. Has that legislation been introduced in the Congress?

Mr. BALL. I believe that legislative language will be sent up in the next couple of weeks.

Senator NUNN. When did the Secretary make the proposal?

Mr. BALL. About a month ago.

Senator NUNN. Was it a press release or what was it?

Mr. BALL. There was a press release, yes, sir.

Senator NUNN. But at that time there was not a bill at that stage?

Mr. BALL. No.

Senator NUNN. But you are working on that?

Mr. BALL. Absolutely, language will be up here in a couple of weeks.

Senator NUNN. In a statement submitted for the record, Gerald Grimes, Commissioner of the Oklahoma State Insurance Department, recommended that we require the Department of Labor to mandate prior approval of MEWA's and the issuance of a license before any entity can claim ERISA status. What do you say to that recommendation?

Mr. **Ball**. With regard to licensing, it is the States that have the authority and should license MEWA's. But with regard to the registry, we are urging a legislative initiative which would require all MEWA's to register. This will enable the States to act quickly and it will also help the small employers and the individuals who are hurt.

Senator **Nunn**. I believe what Commissioner Grimes was talking about was before any entity can claim ERISA status, not MEWA status.

Mr. **Ball**. Well, our proposal is simply to have MEWA's register with the Department, because when we can identify them, we can spot whether they are going across boundaries. If they have not registered, there is a criminal sanction.

Senator **Nunn**. Your proposal is to have them register before they do any business, transact any business?

Mr. **Ball**. Yes, sir.

Senator **Nunn**. Once they register, who then is going to determine whether or not they ought to be in business under this legislation?

Mr. **Ball**. Well, under the current framework, the States have that responsibility.

Senator **Nunn**. How is that registration going to help the States?

Mr. **Ball**. It will enable them to act promptly. If they have complaints or if they wish to identify whether an activity is legitimate, they will be able to find out whether the MEWA has registered. It also should enable us to identify MEWA's across State lines.

Senator **Nunn**. Do they not have to know whether this is really under ERISA or whether it is outside of ERISA, and how is the registration——

Mr. **Ball**. In 1983, Congress amended the law to make it quite clear that there is no preemption for ERISA in this area.

Senator **Nunn**. Now, you heard the testimony this morning and the States say that is just not working.

Mr. **Ball**. Then we should immediately do something about that. As part of the Secretary's initiative, the six-point letter, that is something that will be clarified, because the law is absolutely clear, Congress acted on this matter in 1983 to make it perfectly clear that States had the authority to act in this area. There is no preemption.

Senator **Nunn**. Can you keep us informed as to what you are— you are going to work with the States in trying to clarify this——

Mr. **Ball**. Yes, sir.

Senator **Nunn** [continuing]. Because they all seem to have a problem out there.

Mr. **Ball**. Yes, sir, and Secretary Dole addressed that matter in her letter to the 50 State commissioners.

Senator **Nunn**. When was that sent?

Mr. **Ball**. Yesterday.

Senator **Nunn**. Well, I am delighted that this action is being taken. I think that is helpful. I hope you will keep us informed.

Mr. **Ball**. Yes, sir.

Senator NUNN. Jo Ann Howard testified this morning—she is a member of the Texas State Board of Insurance—she testified this morning about the lack of any Federal certification of ERISA qualified health plans. She stated, "At the heart of the problem is the absence of any kind of Federal certification. This absence has been the well-spring of most of the deception and fraud that has been perpetrated since ERISA's enactment." What do you say to that, Mr. Ball?

Mr. BALL. Well, I go back, Mr. Chairman, to the regulatory framework. Under ERISA, we have one kind of authority with regard to pension plans and a different kind of authority with regard to welfare plans. In this country, the States are given authority fundamentally to regulate the insurance business and we only get into it on a partnership basis. We do not have sole jurisdiction.

Senator NUNN. Mr. Ball, I have been informed by the Insurance Commission in Georgia that they had a proceeding against a multiple-employer welfare arrangement called National Business Association Trust, in which the Georgia authorities had requested assistance from the Pension and Welfare Benefits Adminstration in terms of some expert testimony. It is my understanding that PWBA refused to respond to Georgia's request and that the State ultimately had to subpoena the Department of Labor. Can you tell me, first of all, whether that is accurate, and then can you tell me why, if it is accurate, PWBA refused to provide expert testimony to the Georgia authorities?

Mr. BALL. I have with me my Deputy, Mr. Alan Lebowitz, who would be able to answer that question, if he could come to the table, Mr. Chairman.

Senator NUNN. All right. If he is going to testify, let me give him the oath.

Do you swear that the testimony you give before the Subcommittee will be the truth, the whole truth, and nothing but the truth, so help you, God?

Mr. LEBOWITZ. I do.

Senator NUNN. Thank you.

Did you understand that question or do you want me to repeat it?

Mr. LEBOWITZ. I would appreciate it, Mr. Chairman.

Senator NUNN. What we were told by the Insurance Commission of Georgia is that they had a proceeding against a multiple-employer welfare arrangement called National Business Association Trust. The Georgia authorities had requested assistance from PWBA in terms of expert testimony. I understand PWBA refused to respond to that request and the State ultimately had to subpoena the Department of Labor. The question was whether that information is accurate and, if so, why.

Mr. LEBOWITZ. As best I can remember, Mr. Chairman, we provided the State of Georgia with the assistance that they needed in that case. I do not recall a subpoena. I recall personally having some conversations with the investigator from the Georgia Insurance Commission.

Senator NUNN. What is your policy about individual State proceedings? Do you have a policy on that, whether you do cooperate and furnish witnesses?

Mr. LEBOWITZ. We clearly cooperate in whatever way is feasible. In that particular case, the request was for us to provide a witness, I believe, in an administrative proceeding. We sought to work out a way that we could provide what they needed, without the necessity and the expense of having our people traveling to provide the testimony.

My understanding is that we provided the assistance that they needed. The opinion or the judgment of the Department as to the status of the organization as a covered plan or not was provided and that it was all worked out with the Insurance Commission staff.

Senator NUNN. Could you take a look at your record when you get back and then furnish us any clarification of this that you think is necessary?

Mr. LEBOWITZ. I will sir. One thing I can say——

Senator NUNN. You do not have a policy requiring subpoenas before you have somebody——

Mr. LEBOWITZ. Absolutely not. Our policy is to cooperate in whatever way we can and to help the States in whatever way is feasible.

One thing I can say is we never refused or declined to provide the State of Georgia or any other State——

Senator NUNN. Refused to decline?

Mr. LEBOWITZ. Refused or declined.

Senator NUNN. Oh, or decline. OK.

Mr. LEBOWITZ [continuing]. To provide them with whatever assistance they thought was necessary.

Senator NUNN. Mr. Ball, let me ask you or your assistant, either one: I also understand that, with regard to the National Business Association Trust, that Georgia authorities had sought an opinion letter from Pension and Welfare Benefits Administration as to NBAT's status under ERISA. In its response, PWBA determined that the National Business Association Trust met the definition of multiple-employer welfare arrangement. However, PWBA determined that it was "not necessary at this time to render an opinion as to whether the NBAT is an employee welfare benefit plan."

Subsequently, Georgia wrote back to PWBA, specifically requesting an opinion as to whether the NBAT was an employee benefit plan. PWBA wrote back again refusing to provide Georgia with an opinion on this issue. Can you tell me whether this is a matter of policy or whether this just happened in this case, or do you know?

Mr. LEBOWITZ. I am not familiar with that correspondence, but one point I think is worth keeping in mind, that under ERISA it really does not matter whether the organization is a plan or not, with respect to whether or not the State is free to impose its insurance regulatory framework. The 1983 Amendment that Mr. Ball talked about made it clear that it is irrelevant whether the organization is a plan as to whether the State can regulate the entity or not.

Senator NUNN. Could you also check on that one?

Mr. LEBOWITZ. I will, sir.

Senator NUNN. I guess my real question is whether it is PWBA policy to refuse to provide opinions on whether MEWAs are employee welfare benefit plans. Is that a policy one way or the other?

Mr. LEBOWITZ. No, I think just guessing here, our people thought that it was not really necessary in order for the State to achieve its enforcement objectives. These are often very complicated, very technical issues that can take a long time to resolve, and rather than take that time, our staff simply closed out our proceeding, making it plain that the sequested opinion was not necessary for the State to go ahead with its enforcement proceedings.

Senator NUNN. That is what we are hearing from the States, they agree with you, it takes a long time to resolve anything, and by the time it is resolved, those people have already been victimized and that is what somebody has got to cut through. It is a highly technical area, but somebody—Mr. Ball, I guess we would have to look to you—needs to take a real look at the policy here, talk to these State commissioners—I know that Secretary Dole is corresponding with them now and I congratulate her on that—and find out what the problem is. Somehow, the government has got to work.

Mr. BALL. Absolutely.

Senator NUNN. We have four victims up here and they are not really worried about an esoteric argument of Federal jurisdiction or State jurisdiction, they really want their medical bills to be paid. I have every sympathy with them and that is what we have got a job to do.

Mr. BALL. If we have not responded promptly enough in the past, it is our duty and we expect to provide prompt and fast service to States that ask for help and we will do that.

Senator NUNN. Will you personally——

Mr. MARIA. Excuse me. Might I add that the Inspector General be included with the States, in terms of prompt responses to questions regarding ERISA? We have waited over 21 months for a response from PWBA and the Solicitor's Office as to whether a given plan was ERISA covered or not, because that would dictate the strategy of investigation and, indeed, the violations to be proved. That is 21 months, and we are in the same building.

Senator NUNN. Mr. Ball, would you take it upon yourself to meet with the IG people also from time to time and have some coordination within the building?

Mr. BALL. We have a memoranda of understanding that requires cooperation. Right at this moment, both myself, and I believe Mr. Maria, have asked our enforcement heads to meet together to share information, to work so we can identify cases, so we do not stumble over each other when we are working on cases, and to be more effective in criminal investigations. I have instructed my people to meet, and I understand he has instructed his staff to do the same thing.

Senator NUNN. Will you take it as a personal responsibility to meet with some of these State insurance people, commissioners and board members and make sure you understand the nature of their problem? You do not have to agree with them on everything, I know you are not going to pledge that, but understand what they are faced with in this area and then to let us know the results of that and what initiatives should be taken by the Federal Government, including any changes in law that you might decide need to be taken?

Mr. BALL. Yes, sir, both myself and my staff will see that we do that promptly.

Senator NUNN. Thank you.

Mr. Maria, if the Inspector General's Office were given full investigative authority, what would be the result, in your opinion, in terms of MEWA cases you would be able to investigate?

Mr. MARIA. We would be in a position within one week of opening an additional 53 fraudulent self-funded group health plan investigations.

Senator NUNN. You mean there are that many there that you have spotted?

Mr. MARIA. We have identified facts and circumstances suggestive of fraud, but then again, we are limited only to the Office of Labor Racketeering. It is a finite number of people.

Senator NUNN. If you do not do this, who is going to do it? If you are not given this authority, who is going to have the authority? Who is going to take it on? Is somebody else ready and poised to take this responsibility?

Mr. MARIA. I seriously doubt if anyone will do it. You have heard Mr. Moody testify. There is an expectation by a lot of uninformed people that the FBI is the answer to everything. Indeed, they are the answer to many things, but they have some major priorities and, in just reading their budget testimony, they are inundated in terms of foreign counterintelligence, terrorism, the savings and loan debacle, and——

Senator NUNN. Drugs?

Mr. MARIA [continuing]. And drugs.

Senator NUNN. Mr. Moody, do you have enough to do over there?

Mr. MOODY. We have plenty enough to do.

Senator NUNN. Could you use some help from the Labor Department in this respect?

Mr. MOODY. We can always use help from any department.

Senator NUNN. If I understand your testimony, Mr. Moody, what you are saying is the FBI could tell us how many mail fraud or wire fraud cases it investigated, but not how many of those cases were insurance fraud, how many were securities fraud or commodities fraud or bank fraud, is that right?

Mr. MOODY. That is correct, sir.

Senator NUNN. Do you think it would be possible to have that kind of breakdown, or would that be a whole lot more——

Mr. MOODY. It would take a survey of all of our field offices and, quite frankly, even then if the agent responsible for the cases is no longer with the FBI, we may not be able to pull it back.

Senator NUNN. I am not saying go back, but I am saying from this point forward, how much trouble would it be? I am not trying to recommend this, because I think you would have to give us an analysis of the work involved, but how much——

Mr. MOODY. It would take a survey of all of our current investigations.

Senator NUNN. What about if you just started from this point forward?

Mr. **Moody**. Getting that kind of information——

Senator **Nunn**. Would that be a whole lot of work?

Mr. **Moody**. Yes, sir.

Senator **Nunn**. Just to have another little check spot on the form?

Mr. **Moody**. That is the problem, it is not a form, it is some multiple forms and the procedures that we have set up are very——

Senator **Nunn**. Could you take a look at that and see whether that would be a whole lot and just advise us what your look tells you?

Mr. **Moody**. Yes, sir.

Senator **Nunn**. Mr. Moody, can you tell us how many cases the FBI has referred to the Department of Labor under your memorandum of understanding?

Mr. **Moody**. No, sir, I cannot, without a survey of all the field offices, because the memorandum of understanding, there are four of them, two between the Department of Labor and the Department of Justice and two between the FBI and the Office of Inspector General. We encourage that the sharing of information is done at the field office level and then we also share information at the headquarters level, so the only way I could do that also would be going back to each individual field office to track it.

Senator **Nunn**. How is it possible to assess whether you are getting adequate help from the Department of Labor, then, if you cannot determine what kind of cases you are getting and how many and so forth?

Mr. **Moody**. If we do not know the exact extent of the problem, we are missing the information. I deal in information. If we do not have the information available to us as we need it, something has fallen through the cracks here and it is very difficult to conduct an investigation without the information or being able to identify the exact extent of the crime problem.

If we could in any way increase the availability of the information or expand the extent of the information available or increase the speed in acquiring the information, it would greatly improve our system.

Senator **Nunn**. How do you go about doing that?

Mr. **Moody**. There were some recommendations made by the President's Commission on Organized Crime in 1986, I believe it was, concerning changes that might be enacted by the Department of Labor, like greatly expanding the 5500 form and speeding up computerization and things like that. There is a number of recommendations.

Senator **Nunn**. Have any of those been done or most of them not been done by the Department of labor?

Mr. **Moody**. There are a number of them that have not been done. I would recommend that that might be a starting point for improving the process.

Senator **Nunn**. Mr. Ball, what do you say to that?

Mr. **Ball**. The Form 5500 has been recently revised and over the last few years the department has been in the process of installing a brand new information system which goes into effect for Plan Year 1988. The Form 5500's for that year were filed in July 1989. We have about two-thirds of those forms flowing through. We have targeted objectives that look at the Form 5500 that enable us to identify possible ERISA violations in areas that are fruitful for investigation.

So, with regard to two of the things that Mr. Moody mentioned, we have acted and we are now about to get the benefits of those changes.

Senator NUNN. Could you take a look at the President's Commission on Organized Crime recommendations as they pertain to the Department of Labor and give us a status report about which ones have been implemented and which ones have not, and if they have not, why not and when they will be?

Mr. BALL. Yes, sir.

Senator NUNN. We would like to get that for the record.

I want to thank all of you for being here today. The hearing has been most interesting and informative and I think it gives us all a big challenge here at the Federal level.

I also want to thank the State witnesses who were most helpful.

Mr. Long of North Carolina may want to supplement his statement. If there is any further information about whether the individual here really does have an insurance license or whether that "in the mail" is one of those like you hear from the debtors around. If you would let us know that, we will put that in and make that part of the record.

Thank you.

[Whereupon, at 1:40 p.m., the Subcommittee adjourned to reconvene at the call of the Chair.]

# APPENDIX

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TESTIMONY

OF THE

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

ON

MULTIPLE EMPLOYER WELFARE ARRANGEMENTS

BEFORE THE

UNITED STATES SENATE COMMITTEE ON

GOVERNMENTAL AFFAIRS

PERMANENT SUBCOMMITTEE ON INVESTIGATIONS

Honorable James E. Long
Vice President, NAIC
North Carolina Commissioner of Insurance
May 15, 1990

**Mr. Chairman and Members of the Subcommittee, thank you for this opportunity to discuss the serious issue of health insurance fraud involving multiple employer welfare arrangements ("MEWAs").**[1]

My name is Jim Long. I am Vice President of the National Association of Insurance Commissioners ("NAIC") and the elected Commissioner of Insurance in the State of North Carolina. The NAIC is a nonprofit association whose members are the insurance officials of each state, the District of Columbia, Guam, American Samoa, Puerto Rico and the Virgin Islands.

The NAIC was asked by the Subcommittee to describe what a MEWA is and how MEWAs fit into federal and state regulatory systems. I will also discuss some of the problems state regulators have encountered in this area and how states are responding. My message here today is that states can and will regulate MEWAS and any other health insurance arrangements within their jurisdictions. However, because of the ambiguity and complexity of federal law in this area, a confusing interaction of federal and state authority has resulted; and state insurance regulators often have difficulty identifying and exercising authority over MEWAs until it is too late.

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[1] These arrangements also are sometimes referred to as multiple employer trusts, or METs. I have used the term MEWA because that is the term defined in federal law.

## WHAT EXACTLY IS A MEWA?

The Employee Retirement Income Security Act ("ERISA") was enacted in 1974 to establish uniform federal regulation of employee pension benefit plans and employee welfare benefit plans. ERISA broadly preempts any state law which "relates to" defined employee benefit plans, although state laws regulating insurance and other financial services are "saved" from preemption. At the same time, ERISA prohibits states from "deeming" employee benefit plans as being engaged in the business of insurance. The practical result of these provisions was that states were permitted to continue to regulate the contracts, financial conditions, and other activities of insurance companies but were prohibited from regulating any activities of bona fide employee welfare benefit plans covered by ERISA. This regulatory structure induced many employer and union plans to self-insure to avoid state regulation.

For there to be federal preemption, the health insurance arrangement must be an employee welfare benefit plan as defined in ERISA. Basically, the arrangement must be a "plan, fund, or program," which is "established by an employer or by an employee organization, or by both," which provides "participants or their beneficiaries" with medical, surgical, or other defined benefits.

There are, of course, definitions and court decisions concerning each of these important terms that must be considered in determining whether a health insurance arrangement is an employee welfare benefit plan. Certain types of plans, including government and church plans, are specifically excepted by the statute.

After the passage of ERISA, concerns arose about various associations or groups of employers that formed to provide employee health insurance benefits. These groups claimed to be ERISA covered plans (and therefore exempt from state regulation), although in many cases they did not meet the requirements of a bona fide employee benefit plan under ERISA. In 1983, ERISA was amended to address MEWAs.

The 1983 Erlenborn Amendment ("Amendment") added provisions for MEWAs to Title I of ERISA. A MEWA is defined to include an employee welfare benefit plan, or any other arrangement, that is established or maintained for the purpose of offering or providing medical, surgical, or hospital benefits, or benefits in the event of sickness, accident, disability, or death, to the employees of two or more employers, or to their beneficiaries. Excluded from this definition are collectively bargained agreements, plans provided by a rural electric cooperative, and plans covering two or more trades or businesses under common control. A number of MEWAs have continued to claim exemption from state regulation under a section of the Amendment that permits the Secretary of Labor to exempt employee welfare plans from state regulation. However, no such exemptions have been granted by the Secretary.

Under the Amendment, states have some authority to regulate MEWAs. If a MEWA is fully insured (i.e., its benefits are fully insured by contract or policy of insurance), a state may apply state insurance laws to the extent that such laws provide for the maintenance of specified levels of reserves and specified levels of contributions that must be met in order to pay benefits in full. In addition, state insurance laws apply fully to the insurance contracts and policies guaranteeing the MEWA benefits. With respect to all other MEWAs (i.e., those that are not fully insured), any state insurance law not inconsistent with ERISA may be applied. Because ERISA provisions for employee welfare benefit plans primarily relate to fiduciary and reporting requirements, states are presumably able to apply virtually all their insurance requirements to MEWAs that are not fully insured.[2]

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[2] Here is where an ambiguity may lie and why some states were confused by the Amendment. First, with respect to fully insured MEWAs, states already regulated the insurers and the reserves for their policies. Second, with respect to MEWAs that are not fully insured, the administrators of those MEWAs claimed that because they were authorized by ERISA, they could operate in the state as an unregulated insurer; and that little or no state regulation applied. Because the language in ERISA is unclear, confusion arose about just exactly what states could do about MEWAs operating within their borders.

The practical result of the Amendment is that a state has regulatory authority over a MEWA unless the arrangement is an employee benefit plan as defined by ERISA and the plan is either established pursuant to a collective bargaining arrangement, a rural electric cooperative, or a group of two or more businesses under common control. The scope of this state regulatory authority may vary to some extent as described above. However, the obtuse language in the statute (especially the authority to apply laws "not inconsistent" with the provisions of ERISA) has caused uncertainty and hesitancy on the part of state regulators regarding their authority. This uncertainty causes states to seek cooperation from the U.S. Department of Labor -- cooperation which, from the states' point of view, has not always been forthcoming in the past.

Let me emphasize, however, that it is far easier to describe this statutory scheme than it is to work with it. The language in ERISA is confusing and unnecessarily complex. State insurance regulators literally need to become experts in the field of employee benefits in order to completely understand the scope of their regulatory jurisdiction in this area.

Further, determining the status of a particular MEWA can be a difficult and lengthy process. MEWAs rarely admit that they are subject to state jurisdiction, and states must first investigate the MEWA and then try to assert jurisdiction over the MEWA in an administrative hearing or in court. This usually requires collecting and analyzing the MEWA's trust agreements, bylaws, and other documents. States may request an advisory opinion from the Department of Labor, but this process has been slow in the past. In many cases, the MEWA continues to operate while the investigation is pending.

## HISTORY AND PROBLEMS WITH MEWAS

Before ERISA, most employer health insurance programs were underwritten by licensed, regulated insurance companies. If health insurers became insolvent, most states had guaranty associations or funds that guaranteed the policies issued by insolvent companies and protected the policyholders and beneficiaries, who would receive the benefits they had purchased and relied upon. In drafting ERISA, the essential purpose of which was to protect participants and their beneficiaries from abuses in the handling of pension funds, Congress also exempted certain employer welfare benefit plans from state regulation. Funding levels for these plans were not required, benefits were not required to conform to state insurance laws, and participants were not protected in the event of insolvencies of the plans. Preemption allowed many employers to self-fund their health insurance plans and effectively avoid regulation by any government agency.

Because many smaller employers individually cannot self-insure, they are eager to take advantage of self-insurance programs such as those offered by uninsured MEWAs. MEWAs can be attractive to employers because they are presented as a means to cut the cost of insurance coverage. Generally the rates are lower and all employees are covered because very little medical underwriting is usually performed. These MEWAs claim to be exempt from insurance regulation and do not pay premium tax, do not provide mandated benefits, are not examined, and do not as a rule use actuarially sound rates or maintain adequate claims reserves. The contractual provisions of these MEWAs have been substandard when compared to conventional plans.

States see MEWAs in several forms. In many cases, MEWAs are insured and have group insurance contracts with licensed insurance companies. States are able to regulate these insured arrangements because state insurance laws apply to the contracts and activities of the insurance carriers. In some other cases, MEWAs are self-insured employee benefit plans established through collective bargaining (e.g., Taft-Hartley plans). As discussed above, state regulators have no regulatory authority over these arrangements as long as they meet the ERISA requirements to be an employee welfare benefit plan. State regulation may apply to the stop-loss or excess-of-loss coverage purchased by the plan from an insurance carrier.

The most difficult and harmful type of case involves non-insured or partially-insured MEWAs that are created and marketed by entrepreneurs who claim that ERISA exempts the enterprise from state regulation. Often individuals receive large fees for marketing and administering these MEWAs. In most cases, the MEWAs are not even legitimate employee welfare benefit plans. States are able to assert jurisdiction over these enterprises as "unauthorized insurers" in many instances, and can force them to either comply with the state's insurance laws or cease operation. Unfortunately, by the time state regulators become aware that the MEWA is being marketed and they begin to investigate its legal status and operations, the MEWA may be in serious financial difficulty.

In North Carolina some enterprising insurance agents began to market pooled insurance programs that were not underwritten by licensed insurers on the pretense that such plans were exempted from state regulation. Agents were notified that these entities constituted unauthorized insurers and that they individually would be responsible for the payment of claims and would be subject to license sanctions.

New variations of entrepreneurial MEWAs have appeared recently as well. One type is a staff or employee leasing operation, in which employers are encouraged to terminate their employees and "lease" them back from the staff leasing operator. The operator then self-insures the health benefits of the leased employees, claiming an ERISA exemption from state regulation as a single employer benefit plan. Another type involves unions which agree to provide "associate union" membership to otherwise non-union employees. The MEWA then claims exemption from state regulation as a collectively bargained employee welfare benefit plan. In both cases, the operational structures are a subterfuge to try to hide in the language of ERISA and avoid state regulation.

While the purpose of the Amendment was to clarify state authority, it did not eliminate state and federal problems associated with MEWAs. As described above, trusts and other multi-employer arrangements continue to form and to operate unlicensed and unregulated health plans while claiming exemption under ERISA. Uncovering these operations and bringing them into compliance with state laws can be difficult and time-consuming. Even where state authority is clear, state regulators still must resort to the courts in most cases to finally establish their jurisdiction.

A key problem is the continued ability of these entities to begin operation under a claim of ERISA preemption without prior scrutiny from federal or state regulators. ERISA does not require employee benefit plans to be registered or certified by the Department of Labor. The complexity of ERISA almost encourages false and often fraudulent claims of federal preemption. Small employers do not have the experience or expertise to know that the plans being marketed to them are not under federal control and, usually, are not even legitimate employee benefit plans under ERISA. These small businesses respond to offers of lower rates offered by unlicensed MEWAs. Unfortunately, state insurance departments usually are not contacted until problems arise -- claims are unpaid or the trustees or administrators have disappeared.

Unfortunately, the experience with a vast majority of uninsured MEWAs has been unsatisfactory. There have been cases of mismanagement and out-and-out fraud that have left employees with thousands, and sometimes millions, of dollars of unpaid medical claims. These MEWAs are generally operating on day-to-day bases, relying on premiums from new enrollees to reimburse participants' claims. Their intent is to get as much coverage in force as quickly as possible. It does not take very long to generate a huge amount of premium volume; or for that matter, to generate an even larger amount of claims liability.

## North Carolina's Experience

In North Carolina we have heard the full range of horror stories relating to uninsured health benefit programs. You may have read about the heart transplant recipient who has unpaid medical bills exceeding $200,000; the child born with Spina Bifida; the leukemia patient; and the victims who have postponed or discontinued vital medical treatment because they learned that their health insurance was bogus. We have discovered $409,000 in unpaid claims under one program where the plan has no money to pay claims, and $1,300,000 of unpaid claims in another. We have very little hope that we will be able to get more than a small portion of either of these programs' obligations satisfied. These failures make us very concerned about others operating within our state with little or no cash reserves and with no guaranty fund protection if they suffer the same fate.

There are many victims when one of these programs fails. Reputations of marketing people who took the programs into their portfolio of "insurance" products are destroyed; employers lose the confidence of their employees; individuals end up with bad credit records when their medical bills are not paid; and doctors and hospitals pass the costs on to other patients in the form of higher charges. We have had at least one instance where an employer closed his doors due to the burden placed on his employees; and the employer was located in an area of the state where the 150 jobs he provided were vital to the local economy.

Some of these victims probably should have known better than to become involved in marketing the program and others should have asked a few more questions before they put their employees' health insurance premiums into an uninsured plan. It also appears that ERISA places some obligation on the employer who puts one of these programs in place to cover his employees, but few employees are willing to initiate action against their employers to recover. Even with the very best efforts, far too many claims still remain unpaid.

I plan to have legislation introduced when the North Carolina General Assembly convenes for a budget session next week. Rather than present a voluminous bill to the General Assembly, my legislation will provide for the delegation to the Commissioner of the authority to adopt administrative rules to regulate MEWAs and their administrators. The bill will also contain provisions for licensing, licensing fees, taxes on MEWA contributions, and reimbursement to the State for on-site financial and market conduct examinations and audits of MEWAs and their administrators.

## FEDERAL AND STATE COOPERATION

Unquestionably, the complex federal/state regulatory structure set forth in ERISA has caused much confusion among all the parties involved with MEWAs, including state regulators. In the past, there have been disagreements, and some "finger pointing," between state and federal officials over who was responsible for identifying and taking action against fraudulent MEWAs. While the states had regulatory authority in many cases, the MEWAs claimed that they were operating under a federal statute that broadly preempts state law. States felt that the Department of Labor should provide more assistance in cases where states were questioning a MEWA's claim that it was covered by ERISA.

I hope that these problems are behind us. Cooperation between state and federal agencies has improved in the last year. For example, last fall, the Law Enforcement Coordinating Committee for the District Attorney's Office of the Northern District of Georgia sponsored a seminar on insurance fraud and MEWAs. Insurance regulators from thirty-four states attended to hear presentations made by federal and state experts, including representatives of the U.S. Department of Labor, Pension and Welfare Benefits Administration Division, Office of Labor Racketeering, and Office of Inspector General; the U.S. Department of Justice; and the Georgia and Alabama Insurance Departments. A number of states were in attendance and learned how they could more effectively address the problems caused by uninsured MEWAs.

Officials from the Department of Labor and state insurance departments also participated in a legal education seminar held by the NAIC at its spring meeting in Salt Lake City. In addition, an investigative meeting on uninsured MEWAs involving over ten state insurance departments as well as representatives from the U.S. Departments of Labor and Justices was held just last week in Los Angeles. A similar meeting is planned for the end of May in Atlanta to follow-up on last fall's successful effort.

There are other positive signs for better cooperation as well. Representatives of the Department of Labor have written to and met with the NAIC President to discuss ways that the Department could assist state regulators, including the sharing of information. In addition, Department representatives have assured us that state requests for advisory opinions on whether a particular entity is a MEWA will be given expedited attention. While we do not expect these changes to solve all of the problems related to uninsured MEWAs, we hope that these cooperative efforts will assist both state and federal enforcement actions against these enterprises.

I personally would like to acknowledge cooperation from the Department of Labor, especially acting Inspector General Ray Maria, Joe Gavalis of the Office of Labor Racketeering, and Jim Benages and Bob Surette of the Boston Office of PWBA. They have proven very helpful in investigating cases involving North Carolina citizens as well as in raising the level of awareness of the problem across the country.

## CONCLUSION

Although many legitimate MEWAs are well run and provide valuable benefits to their members, there also are incompetent and fraudulent operators who market "coverage" from unlicensed and uninsured MEWAs to unsuspecting businesses and their employees. When these MEWAs fail, small businesses and their employees can be left without coverage for thousands or even millions of dollars of unpaid medical bills.

State efforts to identify and bring enforcement actions against these uninsured MEWAs are hampered by the federal/state regulatory structure. Because ERISA does not require employee benefit plans to be registered or certified by the Department of Labor, these MEWAs can operate for months or even years before state regulators become aware of their presence. And, even when regulators become aware of a MEWA, they still must examine the plan's documents and operations to determine if it is legitimately exempt from state regulation or operating under a false claim of federal preemption. Often, as discussed above, the damage is done before state regulators have a chance to act.

The NAIC currently is taking steps to assist states in responding more quickly to uninsured MEWAs. An NAIC working group is developing a manual to assist state insurance department investigators and attorneys with their enforcement actions against MEWAs. In addition, the NAIC is improving its information sharing capabilities to assist states in identifying problem MEWAs and individuals associated with problem MEWAs.

One method of identifying uninsured MEWAs that deserves consideration would be a prior registration or licensure requirement for multiple employer arrangements. This would permit federal and state regulators to scrutinize the arrangement before it begins operation. A federal or state registry of MEWAs has been suggested as well.

There are other ideas under consideration. One method of identifying uninsured MEWAs might be to require licensed insurance agents, brokers, and companies (including reinsurers) to identify uninsured MEWAs in the marketplace. Prohibiting these licensees from dealing with uninsured MEWAs might also be considered.

I am convinced that MEWAs need to be thoroughly regulated so that our citizens receive the benefits to which they are entitled. State insurance regulators are committed to addressing the problems brought about by the operation of uninsured and unlicensed MEWAs. We are pleased that the Department of Labor has increased its activities in this area, and we look forward to working with this Subcommittee and other interested parties in finding solutions for this difficult problem.

## n bash

cioty Inc. celebrated its 40th anniversary president, Cheri Hawkins—with colonial ast week. A record number of registrants on employee benefit sessions begin on ssions will appear in the May 14 issue.

# of insurers' deficit

## 6 units may need up to $164 millior

By STACY SHAPIRO

LONDON—Six insurers owned by London United Investments P.L.C. need 75 million to 100 million pounds ($123.2 million to $164.3 million) to remain solvent, says LUI's chief executive.

Meanwhile, brokers and other interested parties still are considering whether to contribute capital to keep the six companies solvent and sure an orderly runoff of their business, according to the chairman of the British Intermediaries & Insurance Brokers Assn.

The six insurers, all of which were running off their business when they stopped paying claims in late March, at one time either participated as insurers on the H.S. Weavers (Underwriting) Agencies Ltd. line slip or reinsured Walbrook Insurance Co. Ltd., another LUI unit and the leading insurer on the line slip.

If the six insurers receive needed capital, Walbrook would not have to increase its reserves for uncollectible reinsurance, said LUI Chief Executive Peter Wilson.

However, any bailout of the companies will take "a couple months" to organize, he said.

Even if the six other LUI insurers are ordered into liquidations, Walbrook would remain solvent, Mr. Wilson said. But the bailout of the six LUI companies "would ensure the solvency of Walbrook" and secure its ability to pay claims, he said.

But, Mr. Wilson said last week that he does not know whether Walbrook could ever begin underwriting again. Walbrook, which in the last few years has written 55% of the Weavers line slip, stopped underwriting in March pending the completion of an actuarial report on the solvency of all LUI insurance subsidiaries (*BI*, April 2).

Anglo American Insurance Co., which until March wrote the other 45% of the Weavers line slip, continues to underwrite from its own offices—rather than Weaver after parting company with W ers last month, according to porary Anglo American derwriter John Steen of John & Partners of New York. An ate, Head Insurance Inves (Bermuda) Ltd., owns A American (*BI*, April 23).

Since joining the Weavers slip in April 1987, Anglo Ame has amassed 200 million po ($328 million) of loss reserves Steen said.

Anglo American was part reinsured by the six troubled companies, but that reinsur was replaced when Head Insu Investors bought Anglo Ame from Calfed Inc. earlier this Mr. Steen said. The amount owed to Anglo American by th LUI insurers is "very small said.

The latest chapter to the We saga was unveiled publicly b Wilson last week following re

*Continued on pa*

## re's Buffett sees
## ompetition ahead

Warren E. Buffett

talking about rate increases, "you need fear on the part of a large number of insurance underwriters" before the market will turn, Mr. Buffett said. That has not yet occurred, he added.

"I would like to talk prices up, too," but significant underwriting losses and a shortage of capacity—not talk—are the driving forces behind rate increases, Mr. Buffett observed.

In fact, in Berkshire's annual report, Mr. Buffett said, "Berkshire's premium volume may drop to $150 million or so in 1990 (from a high of $1 billion in 1986), partly because our traditional business continues to shrink and partly because the contract under which we received 7% of the business of Fireman's Fund expired last August."

Berkshire, through two subsidiaries, reinsured this portion of Fireman's Fund Insurance Cos.' book of business under a four-year quota-share treaty that terminated on Aug. 31, 1989.

"Whatever the size of the (premium) drop, it will not disturb us. We have no interest in writing insurance that carries a mathematical expectation of loss, we experi-

*Continued on page 67*

## Agencies investigate
## benefit fraud charge
## against leasing firm

By DOUGLAS McLEOD

CHARLOTTE, N.C.—Federal and state authorities are investigatin Charlotte labor leasing firm that allegedly defrauded Travelers Ins ance Co. and dozens of small employers in a group employee ben program.

Charlotte-based Cap Staffing Inc., now in bankruptcy proceeding the target of a joint criminal investigation by the North Carolina Ins ance Department, the U.S. Labor Department's Office of Labor Rac teering, the FBI and other federal agencies.

Cap Staffing "leased" workers to small employers, taking over pay and other administrative functions and arranging group accident health and life insurance. Cap self-funded the group health insura program while Travelers provided claims administration services.

However, in a civil fraud suit filed by Travelers, the insurer cha that Cap failed to adequately fund the program, defrauding Traveler more than $800,000 in claims it paid on Cap's behalf over a six-mo period.

Travelers has denied liability for another $1.3 million in claims remain unpaid, citing its "administrative services only" contract Cap Staffing.

*Continued on pa*

NORTH CAROLINA DEPT OF J
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mpanies reap savings
se management tools
Page 2

Risk managers at small firm
are delegating more: Survey
Page 52

## Fraud probe

*Continued from page 1*

While the North Carolina Insurance Department cannot require Travelers to honor the claims, it would like to see the insurer do so and has held two meetings with Travelers' representatives to discuss the problem, said Tony Higgins, senior deputy insurance commissioner.

Mr. Higgins said he feels Travelers should honor the claims because it allowed the program to run for several months without adequate funding from Cap Staffing. He added that promotional literature, claim forms and other material used by Cap all bore Travelers' name and logo.

"I feel for (Travelers) for the $960,000 they're out, but I feel more for the people with $1.3 million in (unpaid claims) outstanding," Mr. Higgins said. "The Cap insureds cannot be expected to know the intricacies of the insurance business."

"It's very frustrating to us to feel as impotent as we do on this," he added, explaining that the most the Insurance Department has been able to do to help Cap insureds is to suggest they sue Travelers.

So far, three lawsuits have been filed against Travelers in North Carolina state courts by workers stuck with unpaid medical bills or by employers suing on workers' behalf, according to A. Todd Brown, a lawyer with the Raleigh, N.C., firm of Hunton & Williams, who represents the insurer.

Two of the lawsuits have also named Cap Staffing, while one names Cap's principal officers, Mr. Brown said.

Travelers, however, maintains that it has no liability for the claims.

"Travelers obviously feels it is just as much a victim as anyone else," Mr. Brown said. "Travelers did nothing wrong and according to the (contract) has no obligation to pick up those claims."

Meanwhile, Travelers' lawsuit against Cap Staffing also alleges that Cap officials fraudulently collected several hundred thousand dollars in contributions to an Individual Retirement Account program that supposedly was invested with Travelers. Travelers, though, was not involved in the IRA program, the suit says.

According to the suit, the Cap officers diverted IRA investments for their own use.

The charges in the Travelers complaint are among the subjects of the federal and state criminal inquiry, which also involves the Internal Revenue Service, the U.S. Postal Service and the federal Social Security Administration, regulatory and legal sources say.

A federal grand jury is hearing evidence from the inquiry, sources say.

The Cap case is also expected to be one of the subjects covered in hearings before the Senate Permanent Subcommittee on Investigations, tentatively scheduled for next week.

The subcommittee, chaired by Sen. Sam Nunn, D-Ga., has been investigating the Cap Staffing case and other instances of alleged abuse of employee benefit plans.

Cap Staffing and an affiliate, Cap Programs Inc., were ordered into Chapter 7 bankruptcy liquidation in November 1989, according to James Ward, a Charlotte certified public accountant who serves as the companies' bankruptcy trustee.

Mr. Ward said he has been unable to identify all the companies' creditors or fix Cap's liabilities because the companies' records were seized by the IRS and the FBI in September 1989, before the bankruptcy petition was filed. These records have been sealed pending the outcome of the grand jury investigation, he said.

However, Mr. Ward said he has compiled a list of more than 100 people who invested $10,000 to $500,000 each with Cap Staffing. Most of these investors rolled over IRA accounts into Cap Staffing in exchange for promissory notes, he said.

A North Carolina state agency seized most of Cap Staffing's assets last August to satisfy a tax lien, and the company's only remaining asset may be $1,000 in a bank account in Greensboro, N.C., Mr. Ward said.

With the company's records under seal, little progress has been made in the bankruptcy proceedings since November, he said.

Travelers filed its fraud suit in U.S. District Court in Charlotte on Oct. 13, 1989. The complaint also names:

- Cap Programs and another affiliate, Cap Leasing of North Carolina Inc.
- Robert W. Long, Cap Staffing's former president.
- Michael Specian, who succeeded Mr. Long as president in 1989.
- D. Ron Harris, former secretary of Cap.
- Michael Krebser, who succeeded Mr. Harris as secretary.
- D.C. Smith, former controller of Cap.
- Jerry M. Wolicki, described as an "assistant to the president" of Cap.
- Steven Lattes, Cap's former vp-insurance administration.

According to the complaint, Cap Staffing entered into contracts with small employers under which the companies' workers became employees of Cap. Cap then "leased" the workers back to the employers, assuming responsibility for the workers' payroll, employee benefits and other administrative functions.

Mr. Harris initially approached Travelers' representatives in Charlotte about providing life, accidental death and dismemberment and health insurance for Cap's leased employees. Travelers submitted a proposal for the coverages, which Cap rejected, the suit says.

Mr. Long and Mr. Harris later went to Travelers' Hartford, Conn., headquarters to discuss other coverage arrangements, and as of Nov. 1, 1988, Cap Staffing entered into an administrative services only contract with Travelers for the health portion of the benefits program, the complaint says.

Under the ASO contract, Travelers was to process claims for a self-funded health insurance plan set up by Cap Staffing. Travelers did not assume any liability for claims under the contract, which provided that Cap would establish a bank account for payment of benefits and make sure enough money was in the account to reimburse Travelers for claim payments the insurer made on Cap's behalf, according to the suit.

Cap collected fees from employers and made payroll deductions from employees' paychecks, purportedly to fund the health benefit program, the suit says.

The insurer also agreed to underwrite life and AD&D coverage for Cap's leased employees.

To attract business to the newly established leasing program, Cap and Messrs. Long, Harris and Wolicki fraudulently represented that Travelers was also underwriting the health coverage available rather than just administering claims, the suit alleges.

While the self-funded health insurance program was intended only for employers leasing their workers from Cap Staffing, the three Cap officials also started offering the coverage to other employers that did not have full-service leasing agreements with Cap.

Cap's self-funded health program covered workers at about 80 companies that had either full-service leasing agreements or other contracts with Cap Staffing, according to the Insurance Department's Mr. Higgins.

Cap initially provided Travelers with a list of 330 covered workers, but the list had grown to more than 3,000 by April 1989, the suit says.

Despite repeated requests, Messrs. Long, Harris and Wolicki failed to update these lists of covered employees or provide Travelers with copies of full-service leasing contracts that would allow the insurer to verify that claims were being submitted by bona fide Cap employees, the suit alleges.

Cap also failed to fund the program with the money it had col-

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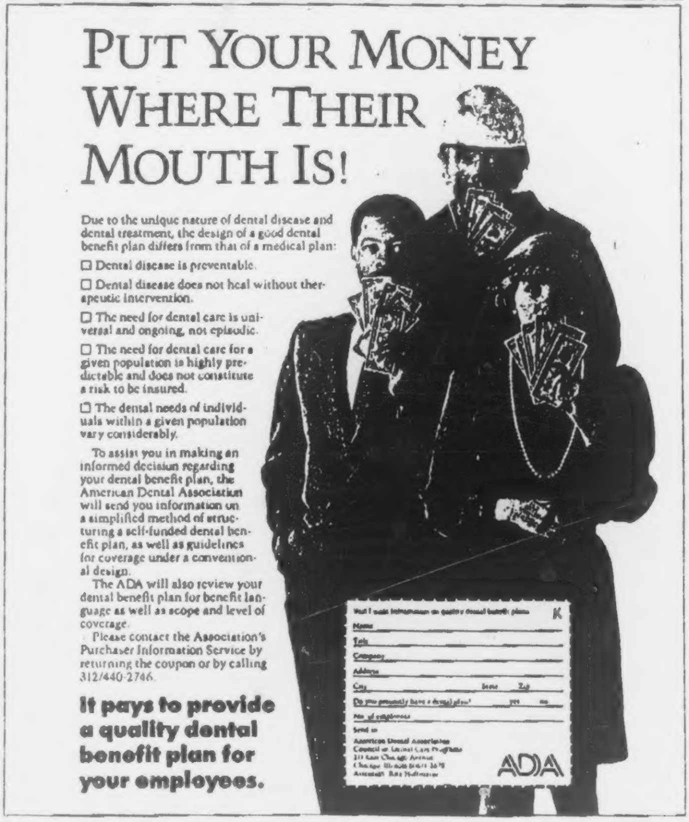

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## Fraud probe

*Continued from previous page*

tected, the suit charges.

Travelers received one check for $4,944.85 in December 1988. A second check for $21,000, sent five months later, bounced, the complaint says. When Travelers threatened to cancel its contract in June 1989—six months after its inception—Messrs. Long, Harris and Wolicki wired $215,000, the suit says.

Travelers—which did cancel on Aug. 1, 1989—is trying to recover $864,779.84 in claims it paid on Cap's behalf without reimbursement, the insurer charges.

An additional $1.3 million in claims has gone unpaid since Travelers bailed out, according to the department's Mr. Higgins.

Asked why Travelers paid so much without reimbursements from the Cap fund, Mr. Brown said Travelers was lulled by assurances from Cap.

"When we were continually getting assurances that 'the check's in the mail,' we sort of believed that these people were on the straight and narrow," he explained.

Meanwhile, Messrs. Long, Harris and Wolicki took money from numerous investors between February and July 1989 in a fraudulent IRA scheme, the complaint also charges.

Cap letters told investors that money contributed to the "Cap Staffing Individual Retirement Custodial Account Plan" was invested with Travelers and would produce a 12% yearly return.

The suit charges that Messrs. Long, Harris and Wolicki falsified an IRA plan submitted to Cap by a local bank, substituting Travelers' name for the bank's name to make it appear the insurer offered the plan.

The three men then converted the IRA money—along with the money intended for the health insurance fund—for their personal use or to their other businesses, the complaint charges.

Mr. Smith, Mr. Spieles, Mr. Kroeber and Mr. Loflin all joined Cap in early 1989 and participated in the fraud with other defendants, the complaint charges.

All defendants except Mr. Long and Mr. Harris have denied the charges in answers to the complaint, said Travelers' lawyer, Mr. Brown.

Neither Mr. Harris nor Mr. Long could be reached.

Entries of default were made against Mr. Long and Mr. Harris after they failed to respond to the lawsuit within the required period. A motion by Mr. Long to set aside the default entry is pending.

In an affidavit supporting his motion, Mr. Long says he relied on Mr. Harris, who he believed to be a former chairman of Travelers.

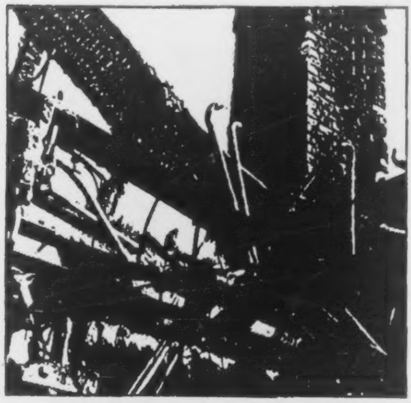
Mr. Brown noted that Mr. Harris was never chairman of Travelers.

Mr. Long also denied that Cap ever executed an administrative services contract with Travelers and said he could not remember whether Cap's "understanding" called for Travelers to administer or to underwrite the health benefit program.

Mr. Long said Cap entered into a June 2, 1989, merger agreement with Gold Equity Management Co. of Palm City, Fla. Cap transferred "a substantial sum of money" to GEMCO, and GEMCO took over responsibility for collecting payments from Cap clients and forwarding them to Travelers, according to Mr. Long. He adds in the affidavit that he does not know if GEMCO ever made any payments to Travelers.

The merger was rescinded on July 31, 1989, as part of a GEMCO plan to set up a new entity, Universal Staffing Associates Inc., the affidavit says.

Mr. Wolicki and Mr. Spieles, who work at Universal Staffing in Palm City, could not be reached for comment. ■



# PROPERTY LOSS

**PUBLISHING: May 28** **AD CLOSING: May 15**

Traditional safety methods coupled with technological innovations are helping risk and loss control managers evaluate and prepare for disasters before they strike.

Business Insurance will devote the May 28 issue to the important area of property loss control, and will provide readers with a single source of information on the best property protection methods available. The topics to be covered will range from cutting-edge technology to traditional methods — from data processing and computers used to locate disasters ... to the more familiar alternatives of sprinklers and firewalls. Editors will also talk to some of the experts — architects and engineers — about loss control procedures including structural engineering and earthquake preparedness.

### DIRECTORY

The Directory of Loss Control Consultants, also contained in this issue, provides the information and the resources needed by risk and loss control managers to do their jobs better.

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In addition to reaching over 155,000* regular readers, this issue will also be distributed at the National Association of Insurance Brokers conference on Sea Island, Georgia. Advertisers in BI reach industry leaders wherever the industry takes them.

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Business

# STATEMENT TO U.S. SENATE PERMANENT SUBCOMMITTEE ON INVESTIGATIONS

*May 15, 1990*

From: Texas State Board of Insurance
Jo Ann Howard, Board Member

5-7-90 final

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# I. Introduction

## *The Health Coverage Dilemma*

Answering the question, "Who Pays?" is the American health care dilemma of the 1990s as the cost of insurance rises and the availability of coverage declines. It is a dilemma for those who have no coverage and for well-intentioned small employers who cannot obtain or afford coverage for their employees. This environment attracts fraudsters who offer bogus health coverage at bargain-basement prices with few or no underwriting restrictions.

One indicator of the extent of the health care crisis is the extremely high number of uninsured Americans, who total 31.5 million to 63 million, depending on the methodology used to count them. These include the homeless and the unemployed, but an estimated 80 percent are in households with at least one employed person.

In many instances, the employers of these uninsured people are small businesses which are having extreme difficulty finding any carrier willing to cover their employees. When small employers do locate coverage, the premiums may soon become unaffordable. Some small employers in Texas have been hit with premium increases of 400 percent in a single year. The Wall Street Journal (October 30, 1989) reported a national trend of affordable first-year rates followed by increases of 60 percent or more for small employers that had major claims.

Meanwhile, many insurance companies are leaving the small group market. An article about this problem in Best's Review (April 1989) was aptly entitled "Where Have All the Players Gone?" The article reported that

> *". . . . well-known insurance companies have either sold or divested their blocks of group insurance. . . . . The list of smaller companies that have abandoned the group insurance marketplace (and particularly the small-group market) is extensive. . . . . As a result, employers and agents have experienced a smaller market and correspondingly higher prices for group health insurance."*

## *"Financial Knaves and Buccaneers"*

In short, the declining availability of health coverage at affordable prices has created an insurance vacuum. Regulators in Texas and other states know from experience that the scientific axiom, "nature abhors a vacuum," is as true for insurance as it is for physical phenomena. Unfortunately, this vacuum all too often is filled by people who are intent on defrauding the innocent.

The very nature of insurance makes it particularly vulnerable to the confidence man. To quote "Failed Promises," the report of Congressman John Dingell's subcommittee investigation of insurance insolvencies:

> *"The business of insurance is uniquely suited to abuse by mismanagement and fraud. Making believable promises is a stock item in every con man's bag of tricks. The prepayment of large, often vast, sums of money with few restrictions lends itself naturally to monumental wasting of assets through greed, incompetence and dereliction of duty. This combination of easy money based on easy promises makes the insurance industry an irresistible target for financial knaves and buccaneers." (p. 3)*

## *The Harm*

The concerns highlighted in this statement to the Senate Permanent Subcommittee on Investigations arise from the hardships inflicted upon consumers by Multiple Employer Welfare Arrangements (MEWAs) spawned by the federal Employee Retirement Income Security Act (ERISA) of 1974. Some of the "financial knaves and buccaneers" to whom Congressman Dingell referred were handed a golden opportunity by this Act and its arguable preemption of state insurance regulation over some of these arrangements. It is far too easy for confidence men to hide behind ERISA and exploit its complexities. The statement will address in detail the regulatory difficulties presented by the Act as these pirates wreak hardship on unsuspecting small employers and their employees who think they have reliable health insurance coverage.

The MEWA issue is not an academic question, a battle for regulatory turf or a skirmish over bureaucratic niceties.

This is a major consumer problem in which unregulated entities sell an essential service, betray the buyer's trust and leave serious financial and emotional injury in their wake.

In a typical scenario, an employer receives an opportunity to obtain group health coverage for his or her employees at an affordable price by joining a self-funded multiple employer arrangement. When operated with fraudulent intent, contributions ("premiums") are set deliberately low – too low to cover all claims over the long run. The plan's funds are siphoned off by unscrupulous promoters, agents and third party administrators. Bankruptcy is inevitable.

When the plan closes its doors, consumers lose their contributions. Their claims go unpaid. They may be hounded by bill collectors on behalf of medical care providers. Future treatment of long-term medical conditions is left in doubt. If they have a chronic condition such as diabetes or heart disease, the formerly covered employees may not be able to find new coverage.

Some of the tragedy following a plan's collapse is similar to what happens when a licensed insurance company fails. But in most states, there at least is a guaranty fund to pay the policyholder claims of licensed insurers. Customers of both legitimate self-funded plans and illegal health insurance arrangements, however, have no such protection.

## *An Overdue Remedy*

Insurance regulators in Texas and other states are concerned that fraudsters capitalize on misrepresentation, operate what amounts to multi-state Ponzi schemes, use time to their advantage and take advantage of a regulatory "black hole" to victimize the public.

This is not a new problem; unfortunately, it has been around far too long. The National Association of Insurance Commissioners raised the problem at hearings in 1978. The Texas State Board of Insurance and other state regulators presented testimony and demanded a solution in testimony to a subcommittee of the House Labor Committee in 1982. So far, the only change has been enactment of the ineffective Erlenborn Amendment in 1982.

Regulators, for the most part, have had to rely upon civil litigation to attack this problem. But injunctions, receiverships and civil penalties are insufficient remedies for the wrongs committed by the promoters of illegal health care plans. Only in the rarest of cases have any of these crooks gone to prison. Civil actions have not stopped these fraudsters; it may be concluded, therefore, that the only realistic deterrent is criminal prosecution and jail time. To achieve this deterrent there must be a stronger federal regulatory role and a strengthening of the federal government's ability to investigate fraudulent self-funded health plans and prosecute those who have profited from the fraud.

# II. ERISA

Astronomical health care costs have led small employers to search for alternatives to traditional health insurance. Passage of the Employee Retirement Income Security Act of 1974 (ERISA) accelerated the trend toward self-funded group health plans. A 1989 survey of employers by A. Foster Higgins & Co. indicated that 52 percent of those who responded were self-funding their employee health benefit plans.

The intent of Title I of ERISA was to offer employers greater flexibility in providing benefits for their employees. Part of this flexibility flowed from ERISA's preemption provisions, which allowed valid employee benefit plans to tailor their own plan provisions without being required to offer state-mandated benefits.

Title I of ERISA seemed intended primarily for large employers with the expertise and sophistication to evaluate alternatives and administer their own plans. However, the emergence of a self-insured market for smaller employers has created problems that were unforeseen when the Act was passed more than 15 years ago.

Small employers may not have a great deal of knowledge about benefit plans and lack the staff or resources to make informed decisions without expert help. When such an employer consults an insurance agent or broker for advice, the agent often will contact insurance companies, other brokers, or third party administrators (TPAs) for bids. Inevitably, employers are faced with two basic options. They can try to find traditional insurance products – including fully insured multiple employer trusts – or they can self-fund.

A comparison of traditional health insurance plans with self-funded arrangements may provide a better understanding of the problems that have arisen.

## *Traditional Health Insurance*

In a traditional health insurance plan, risk is assumed by an insurance carrier licensed to do business in the employer's state. Health insurance carriers are required to maintain specific levels of capital and surplus, pay premium taxes, submit to financial examination, offer benefits mandated by law and comply with state consumer protection laws. In most states, they also are required to pay guaranty fund assessments. A guaranty fund assessment levied upon licensed insurers is the state vehicle whereby funds are provided to pay claims to policyholders whose companies have become insolvent. Most of these requirements were written into the law to protect policyholders, but they do add to the price of coverage. Additionally, health insurance companies apply strict underwriting guidelines[1] to smaller groups. If coverage is offered, the carrier may place restrictions on enrollment, such as exclusion of coverage for pre-existing medical conditions, or outright exclusion of individual high-risk employees. Since many insurance carriers are not interested in the small group market, small employers often are limited in their choice of carriers.

## *Self-Funding Alternatives*

There are definite cost advantages to establishing a self-funded plan under ERISA compared with buying a fully-insured group health policy from an insurance company. ERISA plans pay no premium taxes, are not subject to state financial examination, need not offer state-mandated benefits, do not contribute to guaranty funds, and are largely free of the requirements placed on traditional insurers by state regulation.

There are two self-funding alternatives:

1. Multiple employer welfare arrangements (MEWAs), which often are presented to the employer as "an insurance carrier," and
2. Single employer self-funded health benefit plans.

MEWAs are of two types:

1. multiple employer plans that meet ERISA qualification, and
2. multiple employer welfare arrangements which are composed of heterogeneous groups and are not valid ERISA plans.

The former may be regulated by the state as provided in the Erlenborn Amendment, which is discussed later in this statement; the latter are entitled to no ERISA status whatever and are simply unauthorized insurance subject to all state laws.

Self-funded health benefit plans commonly are marketed by third party administrators, who will handle administrative details and process claims in return for a percentage of contributions.[2]

Third party administrators may play a significant role in the marketing and operation of self-funded MEWAs. Most TPAs opt to control the plan completely – from collection of contributions to claim payment. As little as 50 percent of contributions may remain for actual claim payment after the TPA has taken its expenses off the top. Obviously, the more control the TPA exerts over the plan, the greater the size of fees it can collect. In addition, a MEWA may be marketed through an agent, whose commission also is paid ahead of claims and other legitimate expenses.

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[1] Underwriting is the process by which an insurance company assesses the degree of risk. In health insurance, the company analyzes the morbidity rate, or probability of sizeable medical bills being incurred as the result of accidents and illness.

[2] To avoid confusion, the term "contribution" will be used instead of "premiums," since the latter suggests traditional insurance.

Single-employer plans seldom come to the attention of insurance regulators. Self-funded MEWAs are another matter because most states consider them to be unauthorized insurance, they are actively -- and deceptively -- marketed as "insurance," and they eventually generate a significant volume of claims and complaints.

As indicated in the introduction to this statement, small employers -- those with fewer than 100 employees -- are having great difficulty obtaining group health coverage at an affordable price. Because of their small size and limited resources, few are able to establish single-employer plans under ERISA. They are, therefore, a receptive market for self-funded MEWAs. The experience of Texas demonstrates that a MEWA is a setting for disaster.

In the past seven years, the Texas State Board of Insurance has actively investigated dozens of self-funded MEWAs providing health care coverage to Texas residents. Since Texas does not authorize self-funded MEWAs, such activities are illegal in Texas. Unpaid claims and final monetary judgments, largely uncollected, totaling in excess of $19 million have resulted from seven of these operations. At least six MEWAs covering Texas residents either declared bankruptcy or otherwise became defunct, leaving no appreciable assets for settlement of unpaid claims; it is reasonable to estimate -- in the absence of precise information -- that the unpaid claims of these plans amount to tens of millions more. Several additional MEWAs have been referred to Texas' Attorney General for legal action and are at some point in the litigation process. Dozens of additional cases are in various stages of investigation. Newly established MEWAs surface on an almost weekly basis.

Whether a plan ceased operations as a result of a court order, bankruptcy or some other cause, thousands of Texas plan participants have been left with unpaid medical bills.

## *The Regulatory Framework*

The 1974 ERISA act and subsequent amendments established a pattern of non-regulation, mixed with pockets of limited oversight, that is complex and difficult to interpret. In broad outline [See Attachment A] the framework of federal statutes governing these various health benefit plans works like this:

- Prior to ERISA, the 1945 McCarran-Ferguson Act gave the states full authority to regulate the business of insurance within their boundaries.
- Under ERISA's preemption provision [29 USC Section 1144 (a)], the federal government "regulates" self-funded employee benefit plans and exempts them from state regulation.
- ERISA's Saving Clause [29 USC Section 1144(b)(2)(A)] "saves" from federal preemption those state laws that directly "regulate" insurance.
- However, ERISA also has a "Deemer Clause" [29 USC Section 1144(b)(2)(B)] that is intended to keep states from regulating employee benefit plans by deeming them to be insurance.

- In 1982, Congress passed the "Erlenborn Amendment" [29 USC Section 1144(b)(6)(A)] that gives the states
  1. the power to require insured MEWAs which are *bona fide* ERISA plans to maintain specified levels of reserves and specified levels of contributions and to enforce such standards, and
  2. full regulatory authority over self-funded MEWAs which are *bona fide* ERISA plans – but only to an extent not inconsistent with the rest of Title I of ERISA.
- Finally, 29 USC Section 1002(40)(A) has the effect of exempting multiemployer plans operated under collective bargaining agreements or by rural electric cooperatives from any regulation by the states.

Every MEWA investigated by the Texas State Board of Insurance claimed exemption from state regulation by virtue of ERISA under theories ranging from the mildly plausible to the ridiculous. Regardless of the validity of a claim of exemption from state regulation, the Board and the Texas Attorney General have spent considerable time, money and energy contesting these claims of exemption, generally without assistance from federal authorities. In cases where the state prevailed, usually after prolonged litigation, the operators often had dissipated the MEWA's assets, leaving nothing for payment of valid claims. In several cases, the operators then proceeded to institute new MEWA schemes, starting the cycle all over again.

Two things are clear. First, the judicial process of litigating these cases in the civil courts is expensive, time-consuming, and usually ineffective; by the time a judgment is entered, no funds are on hand for payment. Second, existing remedies, both administrative and judicial, are inadequate to protect the interests of plan participants and do not provide an effective deterrent to illegal operators.

# III. Problems as Seen From the State Perspective

This section of the statement will discuss four specific problems identified by the Texas State Board of Insurance during its investigations of MEWAs over the past seven years. It is followed by a final section offering recommendations for aggressive federal action that is needed to protect small businesses and employees from abuse and fraud.

## *A. Misrepresentation as Insurance Companies*

**Problem: Through deception and misrepresentation, illegal MEWAs encourage the assumption that they are insurance companies. But the regulatory safeguards associated with licensed insurance companies are not present, and consumers are left with unpaid medical bills when these MEWAs fail.**

Fraudulent MEWAs use proposals, application forms, benefit booklets and other materials that make them appear to be licensed insurance companies or which suggest that legitimate insurers stand behind their policies. [Attachment B.]

While regulation is imperfect and not all insurance companies are soundly or ethically operated, their customers do have certain long-established protections. Among these are minimum capital and surplus requirements, mandatory reserving against claims, periodic solvency examinations, guaranty fund participation and state enforcement of unfair claims settlement practices laws. Thus, a MEWA gains a distinct sales advantage if the employer/consumer thinks it is a "real" insurance company.

Letters received by the State Board of Insurance all too frequently bear out the effectiveness of these exercises in deception:

> "I am very sorry to be compelled to complain that the **insurance company**. . . . has refused to settle the claim. . . ."
>
> "We have continually had problems getting claims paid by this **insurance company**. . . . The hospital, radiologist, pathologist, gastroenterologist and doctors are all very upset and wanting to be paid . . . I've called the company . . . . but we can't seem to get their attention."
>
> "My complaint centers around the lack of payment of my medical claim to the proper hospital . . . . I feel the **insurance company** has given me

> the run around and failed to fulfill their responsibility in paying this claim. . . . Is there anybody who can help us with companies who take our hard earned money and failed to fulfill their obligations?"
>
> "Is there anything that you might be able to do for me? I have outstanding claims that this company refused to pay although they say they will."
>
> "It seems that the average citizen is helpless against today's large corporate **insurance companies.**"

Each of these individuals and thousands more like them paid money for plans they had every reason to believe were insurance. The solicitation material distributed by many of these plans talk about being "fully guaranteed insurance" plans.

It is only to be expected that when participants who buy this type of plan have a problem, they turn to state regulatory authorities for help. The Texas State Board of Insurance, for example, received complaints about hundreds of thousands of dollars worth of medical bills that were unpaid bv Rubell Helm Insurance Services, Inc., a California-based operation. In one case, a South Texas cancer victim who thought she had insurance now owes more than $37,000. A collection agency has contacted another of Rubell Helm's "insureds" about more than $3,700 in bills she thought were covered. [See Attachment C for a discussion of Texas' experience with Rubell Helm and Attachment D for the state's district court petition for injunctive relief and civil penalties.] These victims did not draw a distinction between their coverage and insurance policies written by regulated insurers. By the time they complained, the money that might have paid their claims had been drained off. There was no guaranty fund to make them whole.

There is another kind of personal tragedy beyond unpaid medical bills. In some cases, chronically ill people find themselves uninsurable due to their medical condition and are looking down the road to years of medical expenses with no help from the benefit plan they thought they had.

## *B. MEWAs as Ponzi Schemes*

**PROBLEM: Many MEWAs are nothing more than high-stakes Ponzi schemes, paying today's claims with tomorrow's premiums. The absence of any required financial underpinning invites marginal, inexperienced and fraudulent operators into the arena.**

Although the purpose of ERISA was to expand the availability of affordable health care coverage, the promise of the law is empty when the financial structure of the plan is weak. Cheap insurance can prove to be very expensive when claims go unpaid because of underpricing, inadequate reserving and/or misappropriation of plan funds. Unfortunately, these financial defects have been evident in every MEWA investigated by the Texas State Board of Insurance, along with misrepresentation and deception in the marketing of these plans.

Even with the purest of intentions, an unregulated MEWA stands a poor chance of remaining solvent over a long period of time. Cost escalation and rapid change in the medical environment in recent years have made health care coverage extremely difficult to price accurately. Even major insurers with decades of experience are losing money writing accident and health insurance, yet financial requirements for self-funded plans are weak or nonexistent. This can only encourage get-rich-quick schemes by inexperienced and/or unethical operators.

Fraudulent MEWAs are, in effect, Ponzi schemes in which the obligations incurred today are paid from tomorrow's cash flow. It commonly takes 18 months to two years for claims and expenses – including the promoter's "salary" or "administrative fees" – to outrun contributions.

One of the most appalling features of these plans is the fact that they are destined for insolvency from the very beginning. The low rates that make them so alluring to small business people are seriously deficient for the benefits offered. The promoters know this. And they continue marketing these actuarially unsound plans even after they have become clearly insolvent – i.e., unable to pay existing known claims. New participants are necessary to keep the Ponzi going. By the time regulators can take the MEWA to court, additional contributions have been pocketed by the promoter, and the MEWA is broke.

It is necessary to remember that promoters of these schemes deliberately design them in such a way that early, small claims are paid promptly during the initial phase of a MEWA's existence. By paying claims on time and in full, the promoter intentionally avoids generating consumer complaints that would alert insurance regulators and criminal investigators.

When claims no longer can be paid promptly from the cash flow, the consumer receives excuses for the delay:

> "We need more information on your claim;
> "We never received your claim form;
> "We are hiring and training new people;
> "We are changing computer systems;
> "Your claim check is cut and awaiting final review;
> "Your check's in the mail."

These tactics buy time for the promoters to continue collecting contributions and marketing the plan to new participants.[3]

Once consumer complaints have brought a MEWA to regulators' attention, the promoters have still more tricks to prolong their scam. These will be outlined in the next section.

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[3] Licensed insurance companies are responsible for prompt payment of valid claims under the state's Unfair Claims Settlement Practices Act.

## *C. The "Ticking Time Bomb"*

**PROBLEM: MEWAs are ticking time bombs for consumers. Because the racketeers promoting illegal MEWAs sign up new clients and collect millions of dollars in contributions each month, it is essential for the state to be able to verify the plans' legal status swiftly and, if warranted, shut them down immediately. But these crooks use an arsenal of delaying tactics against the states to stretch out the time in which they may continue collecting contributions from unsuspecting employers and employees.**

When confronted by state regulators, a plan invariably responds that it falls within a category protected by ERISA's preemption of state insurance laws. The preemption is available only to:

- Valid single-employer plans,
- Qualified associations (i.e., employers or employee groups in a common line of business),
- Plans developed in conjunction with labor unions through collective bargaining,
- Rural Electric Cooperatives.

In addition to these exceptions under federal law, multiple employer health plans that are **fully insured** by licensed insurance companies are permitted by the insurance laws of most states. Regulators cannot take action through cease-and-desist orders or litigation until they have answered the question: Does the plan in question fit one of these categories?

Illegal plans seem to have all the advantages in the regulators' race against time to ascertain whether they are operating in violation of the law.

### Slow Production of Documents

**Successful civil investigation of alleged unauthorized MEWAs depends upon obtaining full and complete information. Plans and their attorneys thwart the investigative process by dragging their feet when asked to document their status. In one case, a Texas investigator wrote to a plan on November 18, 1988, requesting the information needed to determine whether it was fully insured or, if not, whether it qualified for the ERISA exemption. A second request was sent on December 22, 1988. Still unsuccessful, the investigator wrote to the plan's third party administrator in Massachusetts on January 10, 1989. On January 30, 1989, the TPA's lawyer wrote to say the plan had no Texas participants. On February 13, 1989, Texas pursued its demand for documentation, citing *Article 1.14-1, Section 3(c), Texas Insurance Code* as authority. The TPA's lawyer wrote again on February 23, 1989, requesting a copy of the article, which was provided. More than three months had passed, and the state had obtained none of the basic information needed to determine whether this was a legally operating ERISA plan, exempt from state regulation, or a self-funded MEWA that was violating the insurance laws of Texas. Meanwhile, the MEWA continued to collect millions of dollars in contributions.**

### Fully Insured?

Another stratagem is to claim that a plan is fully insured and, therefore, legal under Texas law. In 1989, a plan claiming to be fully insured sent state investigators down one rabbit trail after another. State Board of Insurance files contain letters from Lexington Insurance Company, Pacific Mutual Life Insurance Company, Transamerica Occidental Life Insurance Company and Blue Cross/Blue Shield of the National Capital Area – all denying any of the connections claimed by the plan.

### Untangling the Web

The process of discerning illegal MEWAs from valid ERISA plans is hampered by the fact that they customarily involve a tangle of insurers, third party administrators, agents and promoters. Each may be in a different state. Each may hold vital records and information. Some parties may be ignorant of what others are doing. In some cases, the role of particular entities is misrepresented by other parties.

In one case, an organization represented itself to ministers and church employees – its targeted clientele -- as "A Blue Cross/Blue Shield Plan." Advertising materials called it a "fully funded, reinsured" health insurance plan. It was, in fact, a self-funded plan which was illegal not only in Texas but also in its home state, South Carolina.

The Texas State Board of Insurance contacted Blue Cross and Blue Shield of South Carolina. Although a wholly-owned subsidiary of the South Carolina Blues was the plan administrator, the advertising materials were prepared and distributed without the knowledge or consent of the Blues. Moreover, the South Carolina Blues said, many of the organization's activities in other states were conducted "without our knowledge and consent."

Paradoxically, the Texas department was contacted by an attorney for this same illegal entity, seeking help in recovering premium collected from some of its members by yet another unauthorized, illegal entity that also catered to ministers. The latter operation was the target of a cease-and-desist order by the Illinois insurance commissioner. Its policyholders had been rolled from one plan to another, but not before they had been milked of another month's contribution.

### Protracted Litigation

The promoters of self-funded MEWAs typically are prepared to fight out in court the twin issues of documentation and regulatory status. Money rightfully belonging to policyholders is plowed into attorney fees, expert witness fees, discovery fees, court costs, travel expenses and the like. The attraction of maintaining a continuing stream of contribution dollars during protracted litigation far exceeds the cost and nuisance of going to court. The value of clever lawyers is illustrated by an alleged agreement by one MEWA to pay its attorney a fixed percentage of contributions received. Meanwhile, the various state attorneys general and the overburdened judicial system have limited resources, upon which many other demands are made. As a result, it is difficult to obtain speedy judgments in civil litigation against promoters of illegal MEWAs.

### Doors That Won't Shut

Even when states finally obtain civil judgments shutting down illegal MEWAs, it is not always clear who really won. It is typical, in fact, for a huckster to surface again with a new, illegal plan.

In Texas, the State Board of Insurance and the Attorney General obtained a permanent injunction closing Bob Earl Browning's Ministers Benefit Trust in 1981. It took Browning less than two years to start over as Christian Organizations Medical Society (COMS). The State Board of Insurance collected a foot-thick file of consumer complaints about COMS, which claimed the ERISA preemption from state regulation. The State Board and the Texas Attorney General went to court against the new Browning operation in 1985. COMS was placed in receivership. Browning's major assets – including a horse farm in Tennessee – were liquidated for the benefit of COMS' policyholders and other creditors. Nonetheless, claims totaling almost $5.4 million remain unpaid. Early in 1990, a federal court convicted Browning of mail fraud in connection with the COMS operation and sentenced him to 15 years in prison; as of May 1, 1990, he was free, pending appeal. This example of a fraudster reappearing on the health benefit scene after authorities had shut down his earlier scams is not unique. There is too much money to be made, and civil litigation by the state becomes just another cost of doing business.

### Intimidation

Verifying ERISA status such as that claimed by Browning, is essential to the states' consumer protection efforts and should be understood and supported by all who are involved with legitimate ERISA plans. Yet, unfortunately, there seems to be an institutionalized attitude among some third party administrators (TPAs) that states have no business digging into claimed ERISA exemptions. The Society of Professional Benefit Administrators in Washington, D.C., issued a six-page memorandum [Attachment E] to state attorneys general and insurance commissioners in September 1989 on limitations of state authority over ERISAs. The memorandum asserted:

> *"Some states are blatantly breaking federal laws. . . . This letter is to help you, the chief legal and insurance officers maximize your effectiveness . . . . without the embarrassment of breaking the law. Please read this carefully and circulate it to the appropriate people on your staff. Also please be sure that any offending laws and requirements are instantly remedied."*

The basic thrust of this threatening memorandum was that state regulators should keep hands off of purported ERISA plans – and particularly the TPAs associated with them. In its defense of the status quo, the Society's memorandum takes a sanguine view of federal regulation of ERISAs. "The federal requirements and restrictions to assure honesty in the plans are extremely tough," the Society said. ". . . . Does ERISA's tough regulation work? Yes.

The Department of Labor has a very active audit investigation and prosecution (civil and criminal) effort." Most state insurance regulators would profoundly disagree, and the Society's assertion conflicts with testimony before Congress by the Department of Labor's acting inspector general, Raymond Maria.

## *D. The Regulatory "Black Hole"*

**PROBLEM: Operators of unlawful MEWAs gain a huge advantage from a regulatory "black hole." Although health plans claiming ERISA status are creatures of the federal government and are often interstate in nature, enforcement is left to the states. Yet the lack of certification by a federal agency or other central authority makes it difficult to verify whether a particular health plan is entitled to ERISA's preemption of state regulation. The U.S. Department of Labor's Pension and Welfare Benefit Administration is slow to respond to requests from the states for information and advisory opinions, and the ERISA statute itself is difficult to interpret.**

Stated as simply as possible, health insurance plans claiming ERISA status are creatures of the federal government. However, the job of policing them has been left to state insurance departments whose limited jurisdiction hampers efforts to protect consumers and shut down illegal operations.

### A Murky Statute

As indicated earlier, the Employee Retirement Income Security Act (ERISA) of 1974 is a patchwork of "gives" and "takes" with respect to state authority over multiple employer self-funded health care plans. Yet the federal government has not created a regulatory framework that clearly establishes whether any particular plan is ERISA-qualified. And that, for both employers and state insurance regulators, is the threshold question that must be answered. Responsible employers want to know whether the health plans offered to them are legitimate operations. State insurance regulators need to know if a particular plan is an illegal venture that must be stopped or one which federal law has shielded from state action.

At the heart of the problem is the absence of any kind of federal certification. This absence has been the wellspring of most of the deception and fraud that has been perpetrated since ERISA's enactment.

### The Employer's Dilemma

An employer faces a dilemma when offered one of these plans. If the employer called the State Board of Insurance and asked, "Is this company licensed in Texas?" he would be told that it is not. The State Board would ask the employer to supply copies of documents obtained from the plan's promoters. In the process, the Board's staff might learn that the plan claimed the ERISA preemption. The employer would be warned that a claim to be a valid ERISA plan may not be true.

The employer might then ask, "How can I determine if it is a valid plan?" It is improbable that the employer will have copies of plan documents or plan booklets. More likely, all he or she has is an offer of cheap insurance. The State Board's staff might advise the employer to call the U.S. Department of Labor (DOL). In the absence of certification or licensure, however, DOL is in no better position than the state to answer the employer's question. It might take months to gather the evidence needed by DOL and additional weeks or months to obtain an opinion. But the employer's workers need coverage now.

The MEWA continues to offer assurances that the plan is valid. The promoter may offer references from other employers to demonstrate that the MEWA pays its claims promptly -- as may be the case in the early stages of its operation. The promoter may also provide a legal opinion from the MEWA's lawyer or encourage the employer to call the attorney directly. If the employer's sales resistance is overcome by these blandishments, another group of victims will have fallen into the regulatory void.

### The Masquerade Ball

Meanwhile, state regulators investigating potential insurance fraud find themselves at a masquerade ball. Illegal operations wear a variety of disguises to make it appear they are entitled to the ERISA preemption. Promoters have shown immense creativity in finding new twists. The latest are (a) bogus membership schemes pretending to be homogeneous associations, (b) employee leasing arrangements camouflaged to resemble valid single-employer self-funded plans, and (c) phony union plans sold to unaffiliated employers which do not have collective bargaining agreements with any labor union.

### PWBA's Ivory Tower

State regulators, therefore, sometimes must ask the Department of Labor's Pension and Welfare Benefit Administration (PWBA) for opinions on whether specific plans qualify for the ERISA preemption of state regulatory authority. Commonly, however, the PWBA never has heard of a particular plan and has no record of its existence. Documentation may not be on file at the Department of Labor (if at all) until months after a plan has gone into business and has begun collecting contributions. When documentation is present, DOL's record of openly and swiftly sharing information with concerned states has been poor.

All too frequently, a state regulatory agency that seeks a PWBA advisory opinion on a plan's status must obtain the necessary documentation on its own. As noted above, MEWAs are less than cooperative in furnishing this information.

After receiving an opinion request and the necessary documentation, the PWBA may then ask the MEWA for its own version. The resulting opinion is based on an "ivory tower" analysis of documents that may have been altered by the MEWA in an attempt to evade state regulation. Because of DOL's failure to dig beneath the surface, its opinions potentially have the effect of elevating form over substance. Thus, one of the few weapons available to the states -- a clear determination of a plan's status by a federal agency -- is rendered useless.

Further, a reading of opinions from the Pension and Welfare Benefit Administration of DOL should demonstrate how unclear and confusing ERISA can be. Samples can be found in Attachment F.

Another recurrent complaint has been the PWBA's seeming inability to produce timely opinions. On November 27, 1989, the insurance commissioners of Texas, Oklahoma and California requested an opinion on a multi-state plan purporting to be a valid Taft-Hartley or union-affiliated plan. The commissioners still awaited a reply on May 1, 1990. Consumers who are being robbed by fraudulent MEWAs do not have that kind of time.

In some instances the PWBA simply issues a non-opinion. In at least two cases last year, employers from Texas complained to the PWBA about nonpayment of claims by self-insured MEWAs. The PWBA replied that it had taken no position on the status of these plans under ERISA. It declared that the ERISA preemption would not apply if the plans were not employee welfare benefit plans under Title I. PWBA's final word in each case was: "You may wish to get in touch with the Texas State Insurance Commission for assistance . . . ."

These plans, however, claimed the ERISA preemption. Because they were unlicensed, the state had no leverage to persuade them to pay policyholders' claims. All the state could do was pursue a time-consuming investigation and prepare for a long battle in the courthouse to shut them down. For the consumer, it was a classic "Catch-22" situation in which everybody was sorry but nobody could help.

In situations like this, the ERISA statute's lack of clarity and the inability of PWBA to make quick, definitive determinations help only the outlaw health plans. The fog is so thick that in a very recent case, a self-insured multiple employer health plan in Amarillo filed suit in federal court for a determination of whether it satisfied all the tests for preemption of state regulation. An attorney for the plan went to great lengths to assure the Texas State Board of Insurance that this was a friendly lawsuit, necessitated by the muddiness of the federal legislation and the inability of PWBA to clarify the situation.

"Unfortunately," the attorney wrote, "almost no guidance is provided by the cases construing the pertinent provisions of ERISA and the Texas Insurance Code respecting regulation of self-insured multiple employer welfare arrangements. Neither is there much counsel to be gleaned from relevant regulations and opinion letters promulgated by the U.S. Department of Labor."

## Hopeful Signs at DOL

There have been hopeful signs recently that the Department of Labor wants to play a more active role in combating fraudulent self-funded health plans.

Both the Office of Inspector General (OIG) and the PWBA recently have approached the states in a spirit of cooperation. Officials of DOL have met with state insurance regulators to share information. The Office of Labor Racketeering, a branch of the OIG, recently assisted in securing federal grand jury indictments against the operators of a plan in Georgia.

Given the magnitude of the harm done by illegal self-funded health care plans, it makes sense to give the Office of the Inspector General and its Office of Labor Racketeering clear authority to investigate alleged criminal activity in ERISA plans and illegal MEWAs.

In addition, the PWBA sent a letter to the National Association of Insurance Commissioners in February 1990, promising to provide "expedited review" of opinion requests from the states. The PWBA also has pledged to distribute advisory opinions on particular plans to all insurance commissioners and to review other filings to determine if they might serve as a basis for listing all identified ERISAs.

These are welcome promises, but regulators must be forgiven if they take a "show me" attitude.

## An Unworkable Amendment

When state regulators complained to Congress in 1982 about fraudulent MEWA activities, Congress' answer was an amendment to ERISA, sponsored by U.S. Representative John Erlenborn of Illinois.

Although the amendment was well intentioned, it did not solve the MEWA problem as Mr. Erlenborn contended in a letter written on December 21, 1989, to Raymond Maria, acting inspector general of the Department of Labor. [Attachment G, Erlenborn letter, with response of Jo Ann Howard, Member, Texas State Board of Insurance.]

The failure of the Erlenborn Amendment to transform ERISA into a model of clarity is indicated by the fact that PWBA's attorneys cannot determine quickly whether a particular plan is exempt from state action.

While the Erlenborn Amendment purported to give the states a degree of regulatory authority over ERISA-qualified self-funded MEWAs, Texas has not chosen to pass legislation asserting such authority. There are several good reasons why such legislation would be an empty, ineffective gesture.

First, the vast majority of MEWAs claiming ERISA status are not valid employee benefit plans subject to Title I of ERISA. If Texas were to pass a law in conformity with the Erlenborn Amendment, to whom would it apply? The Texas State Board of Insurance would be faced with its original problem – the difficulty of obtaining an authoritative opinion as to whether or not a plan qualifies for ERISA status. If it is determined that a plan is not qualified under ERISA, then existing statutes, such as Texas' unauthorized insurance provisions, apply.

Second, assuming that Texas found enough ERISA-qualified MEWAs to justify regulation, the state would wish to impose on such operations standards which are the equivalent of those imposed on insurance companies – i.e., licensure, adequate capitalization, periodic examination and compliance with consumer protection rules.

Finally, such legislation would do nothing to deter fraudulent MEWA operators who are already accustomed to ignoring all regulation whether at the state or federal level.

## Beyond Texas Borders

By default, Congress has left each state regulator with the responsibility of attacking a multi-state problem. Take, for example, the bottom-line question asked by victims of fraudulent MEWAs: Will my claim be paid? In the Rubell Helm case, $700,000 in premiums paid by Texans went to California. The Texas State Board of Insurance and the Texas Attorney General were unable to recover any of this money – through the courts or otherwise. It was spent in California, and very few Texas claims were paid.

The difficulties of investigating and acting against illegal health plans are illustrated by another case. In this example, a plan was headquartered in South Carolina, was represented by agents in Virginia and Georgia and had customers in Texas, Illinois and a number of other states.

In another case, a MEWA operated by a New York third party administrator did business in several other states including Texas, Florida, Minnesota and Wisconsin. A Milwaukee insurance marketing firm helped sell the plan but later disavowed it.

State regulators try to share information as best they can. In August 1978, the insurance commissioner of South Carolina, for instance, notified all other commissioners about the existence of an unauthorized MEWA headquartered in his state and sent along lists of policyholders living within their jurisdictions.

**The states, no matter how hard they might try, are ill-equipped for the task of investigating MEWAs, shutting them down and obtaining financial redress for consumers because:**

1. **It is difficult to enforce subpoenas across state lines;**

2. **Unlicensed ERISAs have nothing to lose – such as a certificate of authority – when they disregard a state regulator's demands; and**

3. **There are conflicts between jurisdictions. A Texas court issued an order directing Louisiana banks to freeze the accounts of a MEWA operating illegally in Texas. Louisiana banks, however, refused to honor the order – even though it was Texans' money that was being frozen. In this case, the Texas Attorney General was forced to obtain a Louisiana court order to safeguard these funds.**

## Criminal Prosecution - A Stronger Deterrent

Through investigation and litigation, states sometimes succeed in uncloaking fraudulent MEWAs and proving that they are operating outside the law. But who really wins? A state may have spent hundreds of thousands of dollars in legal fees and investigative costs. The plan has squandered plan assets on litigation when the money should have been spent paying claims. All the while, new customers have been drawn into the plan, existing customers have paid premiums for which they will never derive benefits and providers have gone unpaid. Only the promoters' lavish lifestyles and fat bank accounts remain relatively unscathed.

In other words, civil litigation has proven ineffective as a deterrent. Civil penalties, court costs and judgments to pay claims are rarely collected. Instead, the promoters just move on to another state or another scam, enriching themselves at the expense of their victims. Evidence at the Bob Earl Browning trial showed he had spent contributions paid by health plan participants on an $800,000 mansion in Fort Worth, 500 acres of prime Tennessee farm land, longhorn cattle and exotic automobiles. In settlement of the state's civil action, Browning relinquished the Tennessee farm but kept cattle, horses, paintings, antiques and some of his cars. This kind of personal wealth is an obscene contrast to the impoverishment the promoters of bogus ERISA plans may have inflicted on unsuspecting working people who depended upon them to cover their medical expenses.

Although criminal prosecution is the only language that the perpetrators of these frauds understand, state insurance regulators are neither criminal prosecutors nor criminal investigators. Nor does their jurisdiction extend across state lines. The state insurance commissioner from Texas, for example, cannot get a wiretap in California.

Federal agencies, however, do have nationwide jurisdiction. But they must also have the resources to perform the necessary investigations and take a winning case into court. What is needed a federal arm with the authority, the money, the people, the expertise and the determination to conduct thorough multi-state investigations and hand fully developed cases to United States District Attorneys for prosecution. There are a number of possibilities. United States postal inspectors, for example, were instrumental in obtaining the Browning conviction. The Office of Labor Racketeering of the Department of Labor has the know-how, the people and – especially important – the will to pursue the pirates that operate these highly profitable interstate swindles.

A determined prosecutorial effort also is necessary. Federal prosecutors across the nation have had their hands full with drug and savings and loan cases, which understandably have a high priority. Some federal prosecutors are reluctant to devote resources to MEWA cases unless several millions of dollars of harm can be shown or federal funds are involved. Naturally, the operators of illegal MEWAs are shrewd enough to avoid federal money. It is important, therefore, for United States District Attorneys to have the resources and the commitment to prosecute this type of organized crime.

# IV. Recommendations for Federal Action

The recommendations contained in this section are intended to address the problems identified in the preceding sections by closing loopholes, improving federal/state cooperation and strengthening oversight at all levels.

- Certification or licensure should be required as a pre-requisite for any plan to claim exemption under ERISA. Existing plans should be given a reasonable period of time to come into compliance but should not be grandfathered. Each certified or licensed plan should be given an identification number and should be required to use the number on all plan documents, consumer coverage cards, applications and solicitation materials.
- Federal statutes or regulations should be amended to state that Section 514 of ERISA does not preempt the authority of the states to investigate claims of ERISA status and to require production of documents and other materials relating to an entity's claim to be a valid ERISA plan.
- It should be a federal criminal offense for any person, group or association to falsely claim ERISA preemption. Operating without a certificate or license should be *prima facie* evidence of violation.
- Adequate federal resources should be committed to the investigation and prosecution of illegal activities involving self-funded MEWAs.
- A federal toll-free WATS line should be established for use in verifying the license status of health care plans.
- Valid plans formed under ERISA should be required to make certain disclosures to prospective and existing policyholders. Disclosures should, at the very least, inform consumers that the plan is not licensed by the state, that the state has no authority to help resolve claim disputes, and that in the event of insolvency there is no guaranty fund protection. In addition, employers who buy such plans should be advised of their potential liability should the plans fail to perform.
- Federal law should require advance notification of participants when a plan is to be converted from fully insured to self-funded.
- Quarterly financial reports on fund balances and liabilities should be required, with automatic criminal penalties for providing false information.

- A method of shared jurisdiction over consumer claim settlement issues should be established whereby the states and the U.S. Department of Labor can share information and resources to investigate and resolve complaints through an interjurisdictional compact.[4]
- All contracts, certificates of coverage and similar documents issued by plans should be required to include a notice of suggested procedure to be followed in the event of a dispute concerning a claim or contribution, along with the name and address of the appropriate regulatory agency from which to seek assistance.[5]
- Documentation on qualifying ERISA plans should be made available to state regulators upon request or through an automated data access system accessible by dial-up computer lines.
- Federal legislation should be passed requiring the trustees, administrators and agents of ERISA plans to maintain documentation and fully disclose it to state insurance regulators upon demand.
- Plans should be required by law to notify plan participants of significant changes in the structure of the plan that could effect their benefits, security or rights.
- Plans should be required to adhere to minimum financial standards as a prerequisite to licensure or certification.
- ERISAs should be required by federal law to notify state insurance regulators when they propose to offer coverage within a state and to allow inspection of documents by state insurance regulators before they market within a state.
- The authority of the U.S. Department of Labor's Office of the Inspector General to investigate alleged criminal activity in ERISA plans and illegal self-funded MEWAs should be expanded.

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[4] The shared jurisdiction for enforcement of equal opportunity laws that now exists between the states and Equal Employment Opportunity Commission under Title VII of the Civil Rights Act of 1964, as amended, could serve as a model.

[5] Patterned after Article 1.35, Texas Insurance Code.

# TESTIMONY TO THE UNITED STATES SENATE PERMANENT SUB-COMMITTEE ON INVESTIGATIONS

by

FLORIDA TREASURER AND INSURANCE COMMISSIONER,
TOM GALLAGHER

May 15, 1990

Thank you for inviting me to speak today.

In my opinion, the State of Florida is a laboratory for the nation on insurance issues because of our demographics: rapid growth; a majority of small businesses; an increasingly international population; and one in which one out of four citizens is elderly.

At a time when the nation as a whole is wrestling to make health care benefits affordable and available, Florida is home to virtually every benefit alternative now being explored.

You could say that we have a lot of experience with the good, the bad and the ugly when it comes to insurance.

One of those alternatives, of course, are multiple employer welfare arrangements, also called MEWAs.

In general, it is our philosophy that we should encourage in Florida a diversity of health benefit options. We want as large and creative a marketplace as possible.

As long as the consumers who purchase these benefits are protected from fraud, from misrepresentation -- and of course from insolvencies -- we believe they should have as many options to choose from as possible.

We encourage consumers to shop around and choose health care benefits that meet their needs and their pocketbook.

MEWAs have been represented as a viable and less expensive health care benefit alternative to insurance or membership in an HMO. MEWAs, it is claimed, make these benefits available and affordable to many Floridians -- especially those in small businesses.

Such a claim is intriguing in a state where more than 90 percent of the businesses are small -- employing fewer than 25 workers.

And there are some MEWA success stories: we have, for example, three authorized MEWAs currently operating in Florida which have provided benefits to thousands of Floridians and their families with few consumer complaints -- and all three show a positive net worth.

At a time when, nationally, consumers are finding these benefits to be increasingly expensive and hard-to-buy, the achievement of these three MEWAs are important. They are delivering needed benefits to their certificate holders.

Unfortunately, the overall picture in Florida is less favorable.

It is our conclusion that dual regulation -- which in some cases and at some points in time has actually been dual nonregulation, has resulted in extreme hardship to many consumers.

Consider:

--In the seven years following ERISA's enactment by Congress in 1974, the Florida Dept. of Insurance detected more than 25 health programs which claimed to be ERISA employee welfare benefit plans that were, in fact, unauthorized insurers. A total of seven of these programs became insolvent, leaving Florida policyholders with millions of dollars of unpaid claims.

--While the 1982 Erlenborn-Burton Act gave the states limited authority to regulate these MEWAs -- this regulation has not fully protected consumers. Florida passed its MEWA law immediately thereafter and has since strengthened it. Unfortunately, by then, the industry had built allies to resist stricter regulation. And, many in this industry have relied on its ambiguous identity -- subject to neither federal-regulation nor state-laws -- to camouflage themselves from effective regulation.

--And finally, while authorized MEWA's have a bad track record in Florida, the unauthorized, bogus operations are even more insidious. They come into our state, selling health insurance at what they say is a cut-rate price. But what they are really selling is illegal insurance offered by a company that is not licensed to do business in Florida. And they do this by throwing up a smoke screen: that they are federally sanctioned by ERISA. They thrive on confusion and the consumer is the victim.

Florida consumers have been victimized by a host of health plans with two things in common: the plans all refused to admit they were subject to state regulation and they all left Florida consumers with unpaid health care claims.

For example, Professional Wrecker Operators of Florida Health and Welfare Benefit Plan was self-funded and claimed an ERISA pre-emption. It left unpaid claims of at least $200,000 before it went out of business in 1987.

A few years ago, the Christian Medical Association began enrolling Florida residents in a group plan. This group targeted ministers, churches and church schools. It also left insureds with unpaid claims before Texas and other states were able to terminate its operation.

Another administrator, Mark I Benefits, began enrolling Florida residents in the International Employers Benefit Trust. This group health plan was open to all industries. Our department worked with the Texas insurance officials to close this operation down. But we weren't successful before the trust became insolvent, leaving insureds with unpaid claims.

Rubell Helm Insurance Services is another example. I have attached to my written testimony a detailed outline of Florida's experience with this outfit.

In brief, Rubell Insurance Services, Inc. began enrolling Florida insureds in a self-funded, California-based MEWA in 1988.

Rubell Helm first claimed to be a fully-insured ERISA plan when, in fact, no insurer provided coverage. Later Rubell Helm stonewalled both Florida and California regulators, claiming to be a self-insured ERISA plan exempt from state regulation.

Under this guise, they signed up about 4,000 Florida insureds in a plan which ultimately left an unpaid claims balance of $3.2 million. The company paid a handful of small claims; it never paid any large claims that we know of. We "shut down" the Florida operation early in 1989, although we believe they continued to operate illegally in other states after that. The corporation is now dissolved with no identifiable assets. The principals in the company can not be located by the department. We have referred the case to federal investigators.

Since Rubell Helm, we have discovered the operation of several other multi-state unauthorized MEWAs providing group health coverage.

Their standard defense is to challenge our jurisdiction. In addition, we are investigating several group insurance plans sponsored by organizations which claim they are exempt from state regulation as Taft Hartley labor unions.

For example, the Consolidated Labor Union, Local 867, marketed a plan in Florida underwritten by Empire Blue Cross Blue Shield of New York. It appears that the premium paid by insureds under this plan passes through a complex series of transactions, with sales costs paid in Florida, Arizona and New York before the premiums reach the insurer -- if they do at all. Empire is not authorized to do business in Florida.

Why is this important? First, there are no guarantees that benefits will be paid, even when the organization has the resources.

Second, we have no regulatory authority over the entity, and benefits and rates bear no correlation to one another.

We have found that employee leasing firms are the most recent trend in welfare plans claiming an ERISA pre-emption of state regulation.

Three benefits which this type of operation provides are: health insurance; payroll services and payment of FICA taxes. In these operations, employers enter into agreements which appear to transfer the hiring and firing of employees to labor leasing companies. The labor leasing company then leases the employees back to the original employer.

Typically, when our department discovers that the leasing arrangement is a subterfuge to primarily provide group insurance, the leasing company claims to be a single employer exempt from state regulation due to ERISA.

For example, Universal Staffing Associates, Inc., of Palm City, Florida, sponsors a plan which includes its own Florida employees and participants from other states. The out-of-state business includes a roll over of insureds from CAPS Staffing, a North Carolina company. Our department is now receiving complaints from out-of-state insureds with unpaid claims due from

Universal Staffing. Universal Staffing recently refused our department's investigative subpoena for production of records to determine jurisdiction. Once again, it appears that the defense will be that the company is not subject to state regulation.

What all of this points to, of course, is the need for more effective regulation.

Let me suggest the following:

The federal government should return complete control of health care arrangements, and especially MEWAs, to the individual states. ERISA should be amended to make it clear that it was primarily designed to regulate pensions. If welfare benefits are to fall under it, let it be for unions and large employers. For little firms, more effective regulation means one master, not two. If Congress were to do that, many of the other suggestions I am addressing now -- and in my written testimony submitted earlier -- would be unnecessary. The real solution is to eliminate duality ... designate one level of government to regulate these health plans and you eliminate the con artists' ability to rely on deceit, ponzi schemes and false hopes of low cost.

My other suggestions are:

1. We would like to see Congress increase criminal and civil penalties for ERISA and MEWA violations and give the states authority to both enforce ERISA and prosecute cases involving fraud and theft.
2. The U.S. Dept. of Labor should be charged by Congress with the job of certifying employee benefit plans -- so that the legitimate plans are clearly identified as such.
3. More resources are needed at the federal and state level to detect ERISA frauds.
4. And we at the state level need to consider stronger laws which I think should require MEWAs to post bonds for protection of insureds, and limit the fees and commissions that an agent or administrator can receive from these so-called "non-profit" companies.

I will be delighted at an appropriate time to respond to any questions. Thank you.

Attachment to:

Testimony to the United States Senate
Permanent Sub-Committee on Investigations
by Florida Treasurer and Insurance Commissioner,
Tom Gallagher

May 15, 1990

Rubell Helm Insurance Services, Inc. (RHISI) is a classic example of a multi-state group benefit plan that used ERISA defenses to avoid state regulation in Florida, California, Texas and Louisiana. RHISI was a California licensed administrator located in Irvine, California.

In February of 1988, Diamond Benefit Life Insurance Company decided to terminate participants in its group plan just before Arizona, its state of domicile, placed it in liquidation. Through contacts within the management of Diamond Benefits, RHISI acquired the mailing list of Florida insureds enrolled in the Diamond Benefit plan. RHISI used this list to inform Florida insureds by mail that it had acquired their block of business and would continue their coverage providing the same benefits at the same rates regardless of pre-existing conditions if the insureds promptly sent their premium payments to RHISI. RHISI initially represented its plan as being fully insured though no carrier ever provided first dollar coverage.

In May of 1988, RHISI began soliciting Florida residents who were members of the Florida Retail Federation Good Health Trust, a Florida licensed MEWA which became insolvent. RHISI made a formal presentation to several key licensed Florida agents, encouraging them to roll their clients over to RHISI and to solicit new business. Once again, RHISI presented its plan as being fully insured, this time by Boston Mutual Life Insurance Company. However, Boston Mutual nor any other bona fide carrier provided any first dollar coverage.

From February, 1988, through February, 1989, RHISI used a variety of marketing names for its plan. In some cases, the same Florida insured made premium payments to: Rubell Helm Insurance Services Plan, American Trust Insurance Plan, Cost Analysis Plan, California Association of Builders Exchange Health and Welfare Trust Plan and National Family Business Association Plan. It appears that RHISI changed the name of the plan as it searched for an insurer to fully underwrite the plan or at least provide stop loss coverage. RHISI apparently attempted to place it's business with American Trust Insurance Company, Fidelity Security Life Insurance Company, Boston Mutual and Diamond Benefit before informing its agents and participants that the plan was a self insured ERISA plan with specific and aggregate reinsurance through a European reinsurance slip.

At one point, RHISI housed all of its Florida business in a plan sponsored by the California Association of Builders Exchange (CABE) which is a bona fide trade association located in California. CABE hired RHISI in 1987 to design and administer a fully insured group benefit plan for the CABE membership. RHISI did not find an insurer to fully underwrite the CABE plan. Boston Mutual provided stop loss coverage for CABE's California membership for a brief period of time. Boston Mutual cancelled this insurance after discovering that multi-state business was commingled in the CABE plan. Eventually RHISI informed the trustees of the CABE Health and Welfare Trust that their plan was a self insured ERISA plan with reinsurance through the European slip. RHISI also informed the CABE trustees that participants from other states were enrolling in the CABE plan and that the plan was in compliance with all state and federal laws.

In February of 1989, the Florida Department of Insurance issued an Immediate Final Order requiring RHISI, CABE and persons representing and aiding RHISI to cease and desist from acting as an unauthorized insurer, MEWA, or third party administrator in Florida. California and Texas also took action against RHISI. In the Florida case, the Department subsequently issued a Consent Order which required RHISI to cease doing business in Florida and to pay all claims. RHISI has not complied with this Consent Order. The Department could file an enforcement action in a Florida court; however, RHISI is now a dissolved corporation with no identifiable assets. Moreover, the location of Michael Rubell and James Helm is unknown to the Department.

The Department has determined that RHISI enrolled approximately 4,000 Florida insureds in its plan leaving an estimated unpaid claim balance of 3.2 million dollars. RHISI initially paid claims all of which were relatively small. It never paid the large claims. As the amount of unpaid claims grew, RHISI issued checks for which it stopped payment or which were returned for insufficient funds. According to the records of the California Department of Insurance, reconciliation of RHISI's bank accounts is complicated because at times RHISI issued two checks with the same number, one as a claim payment and another for some other expense. RHISI would then stop payment on the check for the claim payment and let the check for the expense payment clear. If a person called the bank requesting to know whether the claim check had cleared, giving the check number, that person would be advised that it had cleared.

Florida had about 60 licensed agents involved in the marketing and roll-over of groups into RHISI's plan. Some of these agents never received commissions. Others received commissions after business they placed with Diamond Benefit automatically rolled over to RHISI. A third group of agents received commissions after actively placing business with RHISI. The Florida Department is investigating each instance on a case by case basis.

The Florida Department is also attempting to assist consumers in the filing of claims against the agents' errors and omissions (E & O) coverage where it exists. Some agents' E & O carriers have paid claims. Others have denied claims. Florida Real Estate Agents Alliance is the largest group of Florida insureds enrolled in the RHISI plan. The E & O carrier of the agent who placed that business with RHISI is refusing to pay claims.

Several policyholders and at least one E & O carrier which paid claims for its covered agent have filed civil suits against various defendants including RHISI, CABE, and persons representing and aiding the RHISI plan. These suits include actions filed against Florida agents pursuant to Section 626.901, Florida Statutes, for aiding and representing an unauthorized insurer. All of these suits have been met with ERISA defenses or involve problems with service of process on persons located in California. RHISI's Florida attorney has withdrawn as counsel from one of these suits due to RHISI's failure to pay attorney's fees. In the meantime, collection agencies are bearing down hard on the Florida victims.

Many of the unpaid claims in Florida are too small to warrant expensive litigation. They could be handled most efficiently in a class action suit. The ERISA defenses alleging federal pre-emption of claim procedures discourage the private bar from bringing a class action suit. The Florida Department lacks specific state or federal statutory authority to bring a parens patriae action to recover damages on behalf of Florida insureds.

Many Florida consumers have very large claims. One example is Donna Pavao, an employee of Meldeau International, Inc. Ms. Pavao's claim exceeded $100,000 due to a complicated C-section and the birth of premature twins. Another employer, E.R. Jahna, Inc. had 239 employees. The E & O carrier representing the agent of this group paid over $300,000 in claims. Two individuals had open heart surgery and one other had intestinal cancer. These and many other employers and employees with unpaid claims suffered irreparable financial harm as a result of the unauthorized insurance transactions of RHISI in Florida.

The records of the California Department of Insurance indicate that RHISI was paid excessive fees for administering the plan. In an affidavit, Marilyn Tabor, former controller of RHISI, said money was transferred from premium accounts to operating accounts. The owners, Michael Rubell and James Helm, took $7,100 per week in salaries. That is $369,200 a year. These men used premium accounts to pay approximately $100,000 to a personal tailor and an additional $5,000 to a personal exercise trainer. Other expenses included payments for remodeling the homes of Rubell and Helm and Helm's ex-wife, personal charge card bills of $10,000 to $20,000 a month and $500 a week for psychiatric treatment for Rubell's son. There is no indication that the premium funds were invested to protect the solvency of the plan.

The Florida Department of Insurance has referred its case against RHISI to various state and federal agencies for investigation and possible criminal prosecution.

# MEMORANDUM

TO: Treasurer Gallagher

FROM: Chuck Malloy, Gabriel Mazzeo, and Suzanne Hood

SUBJECT: **The Employee Retirement Income Security Act of 1974 (ERISA) and its Effect on State Regulation of Group Health and Welfare Plans**

DATE: May 7, 1990

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## ERISA and the MULTIPLE EMPLOYER WELFARE ARRANGEMENT

The Employee Retirement Income Security Act (ERISA) was enacted in 1974. It provides minimum federal standards for employee retirement and health benefit programs established and maintained by employers and employee associations. A MEWA is an ERISA health insurance plan entered into by two or more employers. The plan may be (a) self funded, (b) partially self funded and partially funded by one or more insurance and/or reinsurance policies, or (c) fully funded by insurance. ERISA generally provides that state laws seeking to regulate plans which meet the minimum federal standards of ERISA are pre-empted by the federal law.

From the beginning, and particularly in the late '70s and early '80s, states had difficulty regulating MEWAs, third party administrators and insurers which were, or claimed to be, ERISA plans or related to ERISA plans. Each time the states sought to assert their regulatory jurisdiction, the plan, third party administrator or insurer would claim federal ERISA pre-emption. That caused the states to take several paths. They could: (1) go into court to determine whether the plan was in fact exempt and the extent of pre-emption; (2) seek an opinion from the U.S. Department of Labor as to whether the plan was, in fact, ERISA approved and state law was pre-empted; or, (3) simply choose not to assert their jurisdiction.

ERISA was amended in 1983 to clarify that states could regulate MEWAs and were pre-empted only to the limited extent that such regulation was inconsistent with the minimum federal standards. That same year, Florida passed its laws regulating third party administrators and MEWAs. Those laws provided for licensure, minimum state financial requirements, and other minimum state standards.

The enactment of the 1983 federal amendments and state laws provided some relief from unauthorized MEWAs claiming ERISA pre-emption. However, significant problems and abuses still exist. For example, in 1988, Rubell Helm, discussed in more detail later, asserted an ERISA pre-emption defense to state regulation. Before the Department could conclusively resolve the question of Rubell Helm's status under ERISA, Florida claimants incurred millions of dollars in unpaid claims.

## SELF-FUNDED MEWA's VS. FULLY FUNDED GROUP HEALTH INSURANCE

The small business, from 2 to 10 employees, is most likely to be interested in being a part of a self funded or partially self funded MEWA. That is because most larger businesses are able to participate in fully insured group health insurance plans while most small businesses are not.

Insurers are much more prone to want to insure a large business because of the likelihood that "adverse selection" will not be present, i.e. the "bad" risks in a group (because of pre-existing conditions) outnumber the "good" risks which subsidize the "bad" risks in the larger groups. Group health insurance policies must take the group as it finds it and may not exclude coverage of individual participants under Section 627.653, Florida Statutes. Even if insurance is available to the small business, the price is usually exorbitant to make up for the adverse selection.

Since the small business does not generally have the luxury of participating in an insurer funded group plan, it is much more vulnerable to becoming part of a self-funded MEWA. That is where the problems with entities such as Rubell Helm begin.

## INSURANCE DEPARTMENT ENFORCEMENT OPTIONS (AND PROBLEMS)

MEWAs often operate across state boundaries. That makes it much more difficult for the state regulators to assert their jurisdiction against "fraudsters" engaged in the MEWA business. This is particularly true if the "home" state does not have laws similar to Florida's regulating MEWAs. Florida has several options available to it.

### Administrative

The first is through an administrative proceeding. The Department may issue a "cease and desist order" which is like an administrative injunction. If violated after notice and a hearing, it carries a $50,000 penalty. The Department must, however, go through the courts under the Administrative Procedure Act in order to enforce and collect that penalty.

Civil

The second is for the Department to bring a civil proceeding in court for an injunction to prevent the unauthorized MEWA from continuing to operate. Again, however, when reaching across state lines, the penalty for violating the injunction is difficult to enforce. That is because the Florida court's judgment must be turned into a judgment in the appropriate court in the home state and enforced through them. That is expensive, cumbersome and takes a substantial amount of time to bring a closure. Time is the fraudster's best ally.

Criminal

The third is through the criminal laws. One such law is Section 624.437, Florida Statutes. That statute makes it a third-degree felony to aid or participate in an unauthorized MEWA. Problems of enforcement again present themselves, however, because of the reluctance of the state attorneys to have warrants issued for out of state miscreants who must be extradited back to Florida for prosecution. Extradition is also cumbersome and expensive and most often reserved for crimes involving violence and drugs, which are usually first-degree, life or capital felonies.

Compensatory

One final, somewhat effective, law provides that anyone who aids an unauthorized insurer (which is what a non-licensed out of state MEWA is), is liable for the unpaid claims of that insurer. This law has helped claimants collect claims from the errors and omissions coverage of agents who have aided unauthorized MEWAs. The law appears to need some clarification, however, because of the manner in which some of the courts are interpreting it. In addition, suit must generally be brought to collect from the agent's E & O insurer. That makes it difficult for the average consumer or health care provider to collect.

The section that follows gives a brief summary of selected group health and welfare plans that have claimed ERISA pre-emption to state regulation in Florida.

Multiple Employer Trusts

Beginning in the late 1970's and early 1980's, the Florida Department encountered a rash of MET's which claimed exemption to state regulation. Some of these trusts were the result of deliberate attempts to take advantage of the ERISA pre-emption provisions for personal gain. Others were established in good faith by individuals who had insufficient knowledge of the business of insurance to operate successfully without regulation. A few of these trusts are discussed below.

Fringe Facts, Inc., was a Florida corporation which acted as the administrator for several MET's in the early 1980's. The Florida Department had to seek an injunction before Fringe Facts, Inc. would honor the Department's subpoena of records. The insurers who had administrative agreements with Fringe Facts, Inc. began to suspect illegal operations about the same time that the Florida Department initiated its investigation. The insurers eventually cancelled their contracts with Fringe Facts, Inc. which forced it to close down.

Also in the early 1980's, a group of Florida businessmen formed the Florida Health Care Association Benefit Trust. It had over $800,000 in unpaid claims before it closed down. The trustees of this trust worked with the Florida Department for several years thereafter to pay many of these claims.

in 1984, Mark I Benefits, a Texas administrator, began enrolling Florida residents in the International Employers Benefit Trust. This group health plan was open to all industries. The Florida Department worked with the Texas Department to close this operation down, but not before the trust became insolvent leaving insureds with unpaid claims.

In the mid 1980's, the Christian Medical Association began enrolling Florida residents in a group plan. This operation was also based in Texas. It targeted ministers, churches, and church schools. It also left insureds with unpaid claims before Texas and the other Departments could terminate its operation.

The Penta Plan involved an Illinois operation. After the Illinois Department took action against this group, its Florida business was rolled over to the Christian Insurance Association, a South Carolina plan. The South Carolina Department put a stop to this plan's out of state business. The Florida Department had to refer claimants with unpaid claims to the South Carolina Department.

Also in the mid 1980's, a Florida licensed administrator, Dealers Association Plan, transacted business on behalf of several authorized and unauthorized MEWAs. These MEWAs were self funded and claimed ERISA pre-emption. The Florida Department suspended the administrator's certificate of authority to act as a third party administrator.

In 1988, Rubell Helm Insurance Services, Inc. began enrolling Florida insureds in a self funded MEWA located in California. The Florida Department issued an Immediate Final Order against Rubell Helm and other entities and individuals in February, 1989.

Rubell Helm solicited the first Florida participants by mail after acquiring the mailing list of a carrier terminating its group plan. Later, participants in an insolvent licensed Florida MEWA were solicited by licensed Florida agents. The Florida Department has determined that about 60 Florida agents were involved in the marketing of the Rubell Helm plan which used a variety of names: American Trust Insurance Plan, Cost Analyst Plan, CABE Health and Welfare Plan and finally the National Family Business Association Plan. The plan was initially represented as being fully funded, but no carrier ever provided first dollar coverage. It appears that about 4,000 Florida insureds participated in the Rubell Helm plan with an estimated unpaid claim balance of $3.2 million dollars.

Since Rubell Helm, the Florida Department has discovered the operation of several other multi-state unauthorized MEWAs providing group health coverage. The first was sponsored by the Supplemental Benefits Association (SBA) located in Illinois. The SBA Group Insurance Trust was located in Ohio. One of the administrators for the trust was located in Kentucky and the other in Illinois. This business was rolled over to a licensed carrier after the Illinois Department issued an order to cease and desist. This operation used a network of licensed agents to market the plan. The Florida Department is investigating each instance of solicitation on a case by case basis.

Another unauthorized MEWA operating in Florida was the National Business Association Trust located in Kentucky. This trust filed a Petition for Declaratory Judgment in a federal district court to contest the Kentucky Department's jurisdiction to determine jurisdiction. The Florida and Georgia Departments have issued orders requiring the trust to cease and desist operation in their respective states. The Florida Department is also investigating solicitation on behalf of this trust by licensed Florida agents.

## Trusts Established Pursuant to Collective Bargaining Agreements

The Florida Department is currently investigating several group insurance plans sponsored by organizations which claim that the plans are established or maintained pursuant to collective bargaining agreements and therefore exempt from state regulation. For example, the Consolidated Labor Union, Local 867, marketed a plan in Florida underwritten by Empire Blue Cross Blue Shield of New York. Empire is not authorized to do business in Florida. There are approximately 548 Florida certificate holders. The Florida Department issued an Immediate Final Order against the insurer, the administrators and general agencies in April of 1990.

### Labor Leasing

Labor leasing firms are the most recent trend in welfare plans claiming ERISA pre-emption to state regulation. Three characteristics of this type of operation involve health insurance, payroll services and payment of FICA taxes. In these operations, employers enter into agreements which appear to transfer the hiring and firing of employees to labor leasing companies. The labor leasing company then leases the employees back to the original employer. When the Department discovers that the leasing arrangement is a subterfuge to primarily provide group insurance, the leasing company claims to be a single employer exempt from state regulation under ERISA. For example, Universal Staffing Associates, Inc., located in Palm City, Florida, sponsors a plan which includes its own Florida employees and participants from other states. The out-of-state business includes a roll over of South Carolina insureds from CAPS Staffing, a North Carolina company. The Florida Department is now receiving calls from out-of-state insureds with unpaid claims. Universal Staffing Associates, Inc. recently refused to honor the Department's investigative subpoena for production of records to determine jurisdiction.

## SUGGESTIONS

### Federal Level

a. Congress should enact criminal penalties in ERISA which permit states to prosecute actions involving fraud and theft.

b. Congress and the states should enact laws providing for the states and the federal government to bring civil actions for compensatory and punitive (treble) damages on behalf of their citizens (parens patriae).

c. Congress should expand the ERISA claims provisions to include punitive damages for civil causes of action brought by insureds where fraud, malicious intent or reckless disregard for the employee has been proved.

d. Congress should further clarify in ERISA the states' authority to regulate insurers and third party administrators of ERISA plans.

e. Congress should clarify the Erlenborn/Burton amendment to ERISA to reflect that MEWAs as well as insurers and third party administrators related to ERISA MEWAs are subject to state regulation and taxation.

f. ERISA should plainly provide that the states have jurisdiction to determine jurisdiction and that they can take action against entities and individuals claiming ERISA pre-emption where none exists.

g. Congress should provide sufficient personnel and resources to regulate ERISA plans and to enforce the criminal sanctions. The U.S. Department of Labor should have the resources to provide immediate information to states making inquiries about ERISA plans in urgent situations.

h. The federal government should return complete control of health care arrangements, and especially MEWAs to the individual states. ERISA should be amended to make it clear that it only regulates pensions and that health and welfare arrangements constitute insurance which, under McCarran Ferguson, is the proper province of the states.

i. Congress should give the states specific statutory authority to seek injunctive relief in federal district court against out-of-state unauthorized MEWAs or other welfare plans claiming ERISA pre-emption where none exists.

j. Congress should amend the definition of a MEWA to clarify that plans allegedly established and maintained pursuant to one or more collective bargaining agreements are not excepted from the definition of a MEWA unless the Secretary of Labor finds in advance that the exception applies.

State Level

a. The states should enact uniform and reciprocal state laws providing for easier acquisition of jurisdiction and enforcement authority across state lines.

b. The states should educate state court judges (perhaps through the state judges associations) and the private bar on the limited applicability of the ERISA pre-emption to MEWA's.

c. Within the bounds of laws relating to defamation, the states should alert agents and residents about illegal activities on the part of suspected fraudsters.

d. The states should become more involved in the task force meetings sponsored by the various Law Enforcement Coordinating Committees (LECC) established by their respective U.S. Attorneys.

e. States should revise their sentencing guidelines to provide for imprisonment for "white collar criminals" in the more egregious offenses. (The federal government has already done this.)

f. Each state should create a database on unauthorized insurers claiming ERISA pre-emption with the NAIC providing a centralized database for coordination among the states.

g. States should make administrative and criminal investigations and subsequent referrals to the appropriate state and federal prosecutorial agencies a priority assignment.

h. If performance bonds are available, states should require their purchase for agreements made by MEWA's, TPA's and insurers with the states.

i. The State of Florida should encourage all Florida U.S. Attorneys to form a Florida LECC on pension, welfare and union fund abuse to coordinate federal, state and local resources.

j. Each state, under its laws regulating TPA's, should limit the amount of administrative fees (and commissions, if appropriate) a TPA may earn.

## Conclusion

The concept of multiple employer welfare arrangements for small businesses is inherently, and possibly fatally, flawed. That is because adverse selection in those small businesses will not permit the acceptable risks from subsidizing the unacceptable risks without extremely large premiums. Insurers have learned this through many years of experience with premiums and claims. The most that the MEWA can hope to accomplish is somewhat reduced premiums for health care coverage. That is because of fewer dollars being paid for such traditional insurer expenses as agents' commissions, advertising, large physical plants, etc.

GM:SFH:CM:kde

STATEMENT OF
DAVID GEORGE BALL
ASSISTANT SECRETARY FOR PENSION AND WELFARE BENEFITS
U.S. DEPARTMENT OF LABOR
BEFORE THE
PERMANENT SUBCOMMITTEE ON INVESTIGATIONS
COMMITTEE ON GOVERNMENTAL AFFAIRS
U.S. SENATE

MAY 15, 1990

## I. INTRODUCTION

Mr. Chairman and Members of the Subcommittee, my name is David George Ball. I am the Assistant Secretary of Labor for Pension and Welfare Benefits. Accompanying me is Alan D. Lebowitz, the Deputy Assistant Secretary for Program Operations. We are pleased to appear before you today to report on the Department of Labor's regulatory and enforcement efforts, including the assistance we are providing to state regulators, relating to Multiple Employer Welfare Arrangements (MEWAs).

At the outset, I think that it is important that we understand the current federal/state regulatory structure as it relates to MEWAs. The current regulatory structure establishes concurrent Federal-State jurisdiction in the regulation of MEWAs.

The Department of Labor has the responsibility for the administration and enforcement of Title I of the Employee Retirement Income Security Act of 1974 (ERISA). ERISA, among other things, establishes fiduciary and other standards for employer sponsored health plans and broadly preempts state laws related to such plans. ERISA's broad preemption provisions generally reserve sole regulatory and enforcement authority over employee benefit plans to the Federal government. There is, however, an exception from ERISA's preemption provisions for state laws which regulate insurance.

For many years, promoters have established trusts (so-called multiple employer welfare arrangements (MEWAs)), which are set up to market health and welfare benefits to small companies for their employees. MEWAs are often marketed at premium rates that are substantially below rates for comparable coverage from insurance companies, and are thus especially attractive for smaller businesses who find it very difficult to obtain an affordable health program for their employees.

In concept, MEWAs would appear to fill an important void in health care availability. In practice, they may be subject to abuse. This is because they may have inadequate reserves and, therefore, be unable to pay claims. In the worst situation, they may be run by individuals who bleed them dry through extraordinarily high fees and outright embezzlement. While we cannot estimate the number of MEWAs run by unscrupulous promoters, each time a MEWA fails, hundreds and perhaps thousands of participants are left without health coverage for which they paid. Because MEWAs are organized as trusts, they may seek to avoid regulation by state insurance authorities regarding such matters as required reserves and contributions. They may do this by claiming that ERISA's broad preemption provisions prohibit states from imposing such requirements.

However, in the 16 years since ERISA's enactment, it has been extraordinarily rare for the Department to find a MEWA to be immune from state insurance regulation because of ERISA's preemption provisions. Furthermore, Congress amended ERISA in 1983 to make clear that states would be free to regulate these programs under their insurance regulations without the risk of ERISA preemption.

I would now like to turn to a discussion of the role of the states and the Department in regulating MEWAs.

## II. ROLE OF THE STATES IN MEWA REGULATION

Unlike state insurance laws, ERISA does not contain any reserve or contribution requirements for health plans. In addition, there are no rules similar to state insurance requirements relating to the qualifications of persons who operate insurance companies or sell insurance. Thus, while the Department may be able to enforce the ERISA fiduciary standards and applicable federal criminal law against promoters of MEWAs as fiduciaries to plans, these actions are considerably different from, and often more limited than, those generally available to the states under their insurance laws. The states also have the expertise necessary to assess whether MEWAs have adequate liquidity, and to determine, among other things, the proper levels of sales commissions and administrative expenses associated with insurance underwriting.

Because the state insurance laws have substantive requirements for such items as funding, reserves, and qualifications for operating an insurance company and selling insurance products, they can stop unscrupulous promoters by obtaining and enforcing cease and desist orders to prevent them from operating MEWAs in the first instance.

Having addressed the states' authority to regulate MEWAs, I would now like to discuss the Department's responsibility for MEWAs under Title I of ERISA.

## III. DEPARTMENT OF LABOR'S ROLE IN MEWA REGULATION

Very few MEWAs are themselves "employee welfare benefit plans" within the meaning of that term under ERISA and MEWAs are therefore generally not directly subject to Title I of ERISA. However, even if the MEWA itself is not a covered plan, each employer or employee organization which utilizes the MEWA to provide health benefits for its employees or members would be considered to have established and to maintain a separate, single-employer plan subject to ERISA's provisions. Where a MEWA holds assets of such individual plans, the promoters receiving, managing and disposing of these assets are fiduciaries under ERISA and subject to the Department's investigative and enforcement authority, including, where the facts warrant, criminal proceedings.

The Department will ensure that MEWAs are properly operated in accordance with applicable ERISA requirements. Furthermore, the Department is committed to providing the states with all the information and support necessary to regulate MEWA activity over which they have jurisdiction.

## IV. THE DEPARTMENT'S COORDINATION AND ENFORCEMENT ACTIVITIES

The Department maintains an active enforcement program to ensure that fiduciary and other responsibilities under ERISA, including those relating to self-funded welfare plans, are met. The Pension and Welfare Benefits Administration (PWBA) is currently conducting approximately 40 criminal and civil MEWA related investigations. One of these cases is currently being litigated in U.S. District Court. MEWA cases will continue to be a priority under our "significant issue" enforcement strategy.

The Department has recently begun extensive efforts to enhance communications and to share information with the state insurance agencies regarding MEWAs. In my letter dated January 31, 1990, to Congressman William Hughes, Acting Chairman of the Subcommittee on Retirement and Employment, I described in detail the coordination efforts being undertaken between the various PWBA field offices and the states regarding MEWAs. The Department has also exchanged letters with Earl Pomeroy, President of the National Association of Insurance Commissioners (NAIC), which detail these efforts. The NAIC's response has been positive. I ask that these letters be included in the record.

The Department's various field offices' efforts include: regular MEWA meetings between PWBA field offices and the state insurance commissioners' staffs; joint participation in enforcement committees designed to share information and conduct joint investigations; and the presentation by PWBA of training sessions on ERISA to staff of the state insurance commissioners. In addition, I have directed all of PWBA's field offices to have all disclosable portions of their investigations available to the states upon request.

An example of this coordination activity has been demonstrated by PWBA's Boston Area Office. This Office is currently investigating a MEWA and its successor MEWA. The original MEWA is insolvent. It has accumulated unpaid claims of approximately five million dollars ($5 million) with assets of less than one-hundred thousand dollars ($100,000). The successor MEWA is marketed as underwritten by an insurer which provides insurance and reinsurance services to MEWAs located in many different states.

In April of this year, the Boston Area Office wrote to thirty three (33) different state insurance departments in order to provide them information about its investigation of these MEWAs. These states are those in which the insurer has a certificate of authority to write insurance (seventeen), and those in which employers who subscribed to the original MEWA are located. The Boston Area Office's letters also provided the states with a list of the MEWAs which the insurer services, and notified the states that it stands ready to assist them in any way possible.

As a result of this activity, the following actions have occurred:

- The State of Georgia intends to issue a cease and desist order to the insurer barring it from writing insurance business in the state.
- The State of Massachusetts has notified the insurer, which is not licensed or authorized to conduct insurance business in the state, to cease and desist from engaging in any insurance activities in the state unless it complies with Massachusetts law. The state emphasized that the insurer is required to comply with all existing contractual obligations, including payment of any claims.
- The State of Massachusetts has also issued a cease and desist letter barring the provision of any unauthorized insurance business by the original MEWAs' former contract administrator.
- The State of North Carolina is actively involved in the investigation of the original MEWA. Thirty-six (36) contributing employers to the MEWA having unpaid claims are located in the state. North Carolina had issued a cease and desist directive to the insurer in April 1989 directing the insurer to immediately suspend the writing of any further business in the state.

In an effort to further assist the states, the Department has recently undertaken a number of initiatives which I would now like to discuss. These initiatives constitute a six point program to assist the states in dealing with MEWA issues.

## V. DEPARTMENTAL INITIATIVES

### Six Point Program for Aiding the States

1. We are preparing technical assistance materials for the staffs of state agencies. These materials will explain the Department's and the states' roles with respect to MEWAs and ERISA in "plain English."
2. We are exploring with the National Association of Insurance Commissioners the possibility of conducting regional conferences and training sessions on MEWAs and ERISA for the staffs of interested state and Federal agencies. These conferences would be conducted by PWBA independently, or in conjunction with other Federal and state agencies, and the NAIC.
3. We are pursuing cooperative arrangements with appropriate state agencies under which PWBA's Regional Area Offices will share and discuss cases opened and closed by PWBA involving MEWAs. They will make available documents obtained through voluntary production or civil subpoenas.
4. We are providing expedited review of advisory opinion requests from states on the issue of whether a particular entity is a MEWA for purposes of the exception to ERISA preemption of state regulation. The opinions are often critical to states as they proceed

with their enforcement efforts.

5. We are distributing copies of all advisory opinions concerning MEWAs to the Insurance Commissioners of each state on a quarterly basis.
6. We are reviewing the Form 5500 Annual Report filed by employee benefit plans under ERISA, and the ERISA computer database system, to determine whether it is possible to identify MEWAs through the annual reporting process. Our preliminary review indicates that such identification will generally not be possible. However, to the extent that such identification is practicable, we will provide a listing of the identified MEWAs to the states.

We believe these initiatives should make a significant contribution to the formulation of a more cooperative and effective state and Federal strategy for dealing with MEWAs. As I previously indicated, we have met with the president of the NAIC and are encouraged by his support of the initiatives.

## Legislative Initiative

In March of this year, Secretary Dole recommended legislation that would require MEWAs to file registration statements with the Department. Willful failure to file such statements would be subject to the criminal sanctions of section 501 of ERISA. This proposal, we believe, will provide significant assistance to state insurance departments in policing these trusts by providing a national registry of information about MEWAs and the persons who operate them, and should enable the states to act early to prevent situations where contributions and reserves are inadequate to meet benefit claims. It should also benefit small employers and their employees who are the victims of unscrupulous promoters of MEWAs.

The Secretary has also proposed a major budget increase in ERISA enforcement and legal staff. The Department's request of 133 new positions dedicated to ERISA enforcement will generate 1000 new investigations annually in both the pension and welfare plan areas. With this enhancement, we will be in a better position to devote the resources necessary to deal with this apparently growing problem.

## VI. CONCLUSION

We regard the MEWA situation as an important one. However, in all candor, Mr. Chairman, I must tell you that neither we nor anyone else has an accurate picture of the scope of the MEWA problem. We believe that requiring all MEWAs to file registration statements with the Department will enable both the Department and the states to get a handle on the number and location of these entities. If the Department's proposed legislation is enacted, it should be a significant help to the states seeking to assure that MEWAs comply with their insurance laws.

We believe that both the Labor Department and the states have important roles to play in protecting persons who purchase health coverage from MEWAs. We believe that the Department's recent initiatives will be of significant assistance to the states. The Department has made MEWA enforcement a priority and will do all it can to ensure that ERISA's requirements are followed.

This concludes my prepared statement. I would be pleased to answer any questions that you or other members of the Subcommittee may have.

OPENING STATEMENT

OF

JIM E. MOODY

SECTION CHIEF

ORGANIZED CRIME SECTION

CRIMINAL INVESTIGATIVE DIVISION

FEDERAL BUREAU OF INVESTIGATION

BEFORE AN OPEN SESSION

COMMITTEE ON GOVERNMENTAL AFFAIRS

PERMANENT SUBCOMMITTEE ON INVESTIGATIONS

UNITED STATES SENATE

WASHINGTON, D. C.

MAY 15, 1990

MR. CHAIRMAN, AND MEMBERS OF THE COMMITTEE, I AM PLEASED TO HAVE THIS OPPORTUNITY TO APPEAR BEFORE YOU TODAY AND PROVIDE TESTIMONY.

ON APRIL 11, 1988, THIS SUBCOMMITTEE RECEIVED THE TESTIMONY OF DIRECTOR SESSIONS, WHICH DETAILED OUR INVESTIGATIVE STRATEGY AND SUCCESSFUL INVESTIGATION OF THE LA COSA NOSTRA, OR LCN, OVER THE LAST 25 YEARS. ON APRIL 12, 1989, FLOYD I. CLARKE, THEN EXECUTIVE ASSISTANT DIRECTOR AND NOW DEPUTY DIRECTOR OF THE FEDERAL BUREAU OF INVESTIGATION (FBI), ADDRESSED THIS SUBCOMMITTEE ON THE FBI'S POLICIES, STRATEGIES, AND PROGRESS AGAINST ORGANIZED CRIME AS WELL AS FBI INVESTIGATION AND USE OF CIVIL REMEDIES AS PROVIDED BY THE RACKETEER INFLUENCED AND CORRUPT ORGANIZATIONS (RICO) STATUTE. WE BELIEVE THE FBI HAS ACHIEVED UNPRECEDENTED SUCCESS IN THE WAR AGAINST ORGANIZED CRIME. THESE SUCCESSES LED TO THE DEVELOPMENT AND IMPLEMENTATION OF AN ORGANIZED CRIME NATIONAL STRATEGY, AND FULLY UTILIZED THE ENTERPRISE THEORY OF INVESTIGATION. NATIONWIDE MANAGEMENT OF THE FBI'S ORGANIZED CRIME PROGRAM REQUIRES ADHERENCE TO THAT STRATEGY AND CONSTANT REEVALUATION OF INVESTIGATIVE PRIORITIES AND RESOURCE ALLOCATIONS TO ACCOMPLISH ITS GOALS AND OBJECTIVES. WITHOUT SUCH OVERSIGHT, CURRENT RESOURCES DEDICATED TO THE INVESTIGATION OF ORGANIZED CRIME WOULD NOT HAVE BROUGHT THE "COMMISSION" OF THE LCN TO JUSTICE, NOR WOULD THE FBI'S MAJOR PROSECUTIONS OF LCN FAMILIES NATIONWIDE HAVE BEEN ACCOMPLISHED.

LABOR RACKETEERING VIOLATIONS, AS COMMITTED BY ORGANIZED CRIME GROUPS, OCCUPY THE HIGHEST PRIORITY WITHIN OUR NATIONAL STRATEGY. AS A RESULT, MANY OF OUR EXPANSIVE INVESTIGATIONS AND SUBSEQUENT PROSECUTIONS OF ORGANIZED CRIME ENTERPRISES ARE BASED, IN PART, UPON LABOR RACKETEERING PREDICATES, INCLUDING VIOLATIONS OF TITLE 18, UNITED STATES CODE, RELATING TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974, OR ERISA. THE MASSIVE CIVIL RICO COMPLAINT AGAINST THE GENERAL EXECUTIVE BOARD OF THE INTERNATIONAL BROTHERHOOD OF TEAMSTERS, THE "COMMISSION" OF THE LCN, AND NUMEROUS LCN MEMBERS AND ASSOCIATES NATIONWIDE, WAS BASED UPON INFORMATION GLEANED FROM 213 CRIMINAL INVESTIGATIONS OF LCN MEMBERS AND ASSOCIATES INVOLVED IN LABOR RACKETEERING ACTIVITIES. ON FEBRUARY 6, 1990, TWENTY MEMBERS AND ASSOCIATES OF THE VIOLENT STREET CREW OF FORMER CHICAGO LCN BOSS JOSEPH FERRIOLA WERE INDICTED. ON MARCH 22, 1990, THE HIERARCHY OF THE PATRIARCA LCN FAMILY WAS INDICTED IN BOSTON, PROVIDENCE, AND NEW HAVEN. THE PATRIARCA INDICTMENT IS PARTIALLY COMPRISED OF LABOR RACKETEERING MATTERS, AND ALTHOUGH THE FERRIOLA INDICTMENT DOES NOT CONTAIN A LABOR PREDICATE, THE PROSECUTION WILL HAVE SIGNIFICANT IMPACT ON AN ORGANIZATION THAT IS HEAVILY INVOLVED IN LABOR RACKETEERING. THIS COMMITTEE RECEIVED TESTIMONY FROM DIRECTOR SESSIONS DETAILING MANY FAR-REACHING PROSECUTIONS OF MAJOR LCN FAMILIES, THE PREDICATE BASES OF WHICH WERE LABOR RACKETEERING VIOLATIONS. CURRENT INITIATIVES SUGGEST A CONTINUED STEADY PROGRESS IN OUR MISSION, AS STATED IN OUR NATIONAL STRATEGY, "TO REMOVE THE LCN

AS A SIGNIFICANT THREAT TO AMERICAN SOCIETY."

THE FBI AND THE DEPARTMENT OF LABOR HAVE CONCURRENT INVESTIGATIVE JURISDICTION OVER CRIMINAL VIOLATIONS OF ERISA AND SELECTED LABOR-RELATED VIOLATIONS OF TITLES 18 AND 29, UNITED STATES CODE, APPLICABLE TO MULTIPLE EMPLOYER WELFARE ARRANGEMENTS, OR MEWAS. IT SHOULD BE NOTED THAT A MEWA IS AN EMPLOYEE WELFARE ARRANGEMENT ESTABLISHED OR MAINTAINED BY TWO OR MORE EMPLOYERS FOR THE BENEFIT OF THEIR EMPLOYEES IN WHICH THE SUBSCRIBING EMPLOYERS HAVE NO COMMON RELATIONSHIP SUCH AS THAT DERIVED FROM A COMMON CONTROL GROUP OR PARTICIPATION IN A COLLECTIVE BARGAINING AGREEMENT, I.E., EMPLOYEES ARE NOT REPRESENTED BY A LABOR UNION AND THE "WELFARE ARRANGEMENT" IS PROVIDED BY THE EMPLOYER AS A BENEFIT OF EMPLOYMENT NOT AS A LABOR-MANAGEMENT CONTRACTUALLY BARGAINED OBLIGATION. ALTHOUGH MOST MEWAS ARE NOT REGARDED AS EMPLOYEE BENEFIT PLANS THEMSELVES, THOSE ARRANGEMENTS FREQUENTLY PROVIDE HEALTH AND OTHER WELFARE BENEFITS FOR SMALL EMPLOYERS WHO BY THEIR FINANCIAL SUBSCRIPTION TO THE MEWA PROGRAM, ESTABLISH BENEFIT PLANS FOR THEIR EMPLOYEES WHICH ARE SUBJECT TO FEDERAL REGULATION UNDER ERISA. THE FBI/DEPARTMENT OF LABOR CONCURRENT JURISDICTION OVER MEWAS IS DERIVED FROM STATUTORY DELEGATION AS WELL AS BY MEMORANDA OF UNDERSTANDING. THE FBI'S INTELLIGENCE BASE DOES NOT INDICATE THAT MEWA'S HAVE BEEN SOLELY OR SELECTIVELY TARGETED BY ORGANIZED CRIME GROUPS. HOWEVER, INDUSTRY SERVICE PROVIDERS, SUCH AS THIRD PARTY ADMINISTRATORS, OR, LABOR CONSULTANTS WHO SERVICE NUMEROUS EMPLOYEE BENEFIT ARRANGEMENTS WHICH MAY INCLUDE MEWAS, HAVE

BROKERED ILLEGAL BUSINESS TRANSACTIONS AND/OR FRAUDULENT SCHEMES THAT HAVE BEEN INVESTIGATED BY THE FBI AND HAVE BEEN PROSECUTED FOR THEIR INVOLVEMENT WITH ORGANIZED CRIME MEMBERS AS PART OF RACKETEER ENTERPRISES. FOR EXAMPLE, THE NATIONWIDE JOINT FBI/OFFICE OF LABOR RACKETEERING INVESTIGATION CODENAMED "DENTEX," WE BELIEVE, DEMONSTRATES LCN CONTROL AND INFLUENCE OVER THE OPERATIONS OF 12 HEALTH AND WELFARE PLANS IN SEVEN CITIES. CRIMINAL VIOLATIONS RELATING TO ERISA COVERED PLANS, MAIL FRAUD, FRAUD BY WIRE, AND CONSPIRACY SERVED AS PREDICATE BASES FOR RACKETEERING INDICTMENTS OF THE PLAN ADMINISTRATORS.

THE TOP INVESTIGATIVE PRIORITY OF OUR ORGANIZED CRIME NATIONAL STRATEGY IS THE "DETECTION OF ORGANIZED CRIME INFLUENCE, INFILTRATION, CONTROL OR DOMINATION OF LEGITIMATE BUSINESSES AND/OR LABOR UNIONS IN OUR SOCIETY AND THE ERADICATION OF THAT PRESENCE." TO ACHIEVE THAT OBJECTIVE, ALL COMPLAINTS OR ALLEGATIONS RECEIVED BY THE FBI WHICH PERTAIN TO LABOR-RELATED VIOLATIONS ARE REVIEWED AND EVALUATED WITH RESPECT TO THE INVOLVEMENT OF ORGANIZED CRIME AND CURRENT PROSECUTIVE GUIDELINES. COMPLAINTS WHICH ARE APPARENT ERISA MATTERS FALL WITHIN THE RESPONSIBILITIES OF THE ORGANIZED CRIME PROGRAM. WHEN THE ORGANIZED CRIME ELEMENT IS NOT PRESENT, AND/OR THE MINIMUM PROSECUTIVE CRITERIA FOR ERISA MATTERS ARE NOT MET, THE COMPLAINT OR ALLEGATION IS FORWARDED TO THE DEPARTMENT OF LABOR, IN ACCORDANCE WITH OUR MEMORANDA OF UNDERSTANDING, FOR THEIR REGULATORY AND INVESTIGATIVE CONSIDERATION. THIS CASE ADMINISTRATION IS NECESSARY FOR THE EFFICIENT USE OF ORGANIZED

CRIME PROGRAM RESOURCES, OUR INVESTIGATIVE MISSION, AND PRIORITIES AS DEFINED BY OUR NATIONAL STRATEGY. THE FBI MAKES REFERRAL OF SUCH LABOR MATTERS WITH THE REALIZATION THAT THE DEPARTMENT OF LABOR, AS A REGULATORY AND ENFORCEMENT AGENCY, PLAYS A ROLE IN THE DETECTION AND INVESTIGATION OF ENTITIES INVOLVED IN FRAUDULENTLY OPERATED MEWAS, AND THAT THE REFERRED INFORMATION MAY BE USEFUL.

UPON THE RECEIPT OF A NON-ORGANIZED CRIME OR LABOR RACKETEERING COMPLAINT, OR BASED UPON SOME OTHER CASE PREDICATION SUCH AS INFORMANT AND/OR INTELLIGENCE DATA, THE FACTS AND CIRCUMSTANCES OF MATTERS THAT FALL WITHIN PARTICULAR PROGRAM PRIORITIES ARE PRESENTED BY FBI FIELD OFFICES TO THE UNITED STATES ATTORNEY FOR INITIAL PROSECUTIVE OPINION. BECAUSE A VARIETY OF SUBSTANTIVE VIOLATIONS ARE CHARACTERISTIC OF A POSSIBLY MISMANAGED OR CORRUPTED MEWA, A CASE OF SUFFICIENT PRIORITY MIGHT, WITH FAVORABLE PROSECUTIVE OPINION, BE OPENED. DEPENDING UPON THE CONSTRUCTION AND ADMINISTRATION OF THE MEWA, SUBSTANTIVE VIOLATIONS OF THE MAIL FRAUD, WIRE FRAUD, AND VARIOUS BANKING AND/OR SECURITIES FRAUD STATUTES ARE PROBABLE, AND WOULD PLACE THE FBI'S PRIMARY JURISDICTION WITHIN OUR WHITE COLLAR CRIMES PROGRAM. THE INVESTIGATION WOULD BE CONDUCTED ACCORDING TO PROGRAM PRIORITIES AND THE PROSECUTIVE OPINIONS AND STANDARDS OF THE RESPECTIVE OFFICES OF THE UNITED STATES ATTORNEY. IF AN INVESTIGATION IS INITIATED, DEPENDING ON THE NUMBER AND MAGNITUDE OF OFFENSES COMMITTED BY THE PRINCIPAL SUBJECTS, APPLICATION OF THE RICO STATUTE MIGHT BE APPROPRIATE IN THE PROSECUTION OF

VIOLATIONS INVOLVING MEWA'S, EVEN WITHIN THE WHITE COLLAR CRIMES PROGRAM. AGAIN, IN THE EVENT THAT AN ALLEGATION IS RECEIVED, WHICH DOES NOT MEET WHITE COLLAR CRIMES PROGRAM PRIORITIES OR UNITED STATES ATTORNEY STANDARDS, IT IS THE POLICY OF THE FBI TO MAKE APPROPRIATE REFERRALS TO THE DEPARTMENT OF LABOR FOR THEIR INFORMATION AND USE IN THEIR INVESTIGATIVE RESPONSIBILITIES.

THE FBI HAS 269 INVESTIGATIVE AND ADMINISTRATIVE CLASSIFICATIONS OF STATUTORY LAW WHICH PROVIDE THE FBI WITH SOLE, PRIMARY AND/OR CONCURRENT JURISDICTION WITH OTHER FEDERAL AGENCIES. IN THE AREA OF OVERLAPPING OR CONCURRENT JURISDICTION, MEMORANDA OF UNDERSTANDING HAVE BEEN EXECUTED WITH THESE AGENCIES TO AVOID DUPLICATIVE OR WASTEFUL USAGE OF INVESTIGATIVE RESOURCES. WE ATTACH IMPORTANCE TO THESE MEMORANDA OF UNDERSTANDING AND MAKE INVESTIGATIVE REFERRALS WHEN APPROPRIATE. AS RECENTLY AS APRIL 13, 1990, WE RE-EMPHASIZED TO OUR FIELD DIVISIONS THE PROVISIONS OF OUR ORGANIZED CRIME/LABOR RACKETEERING MEMORANDUM OF UNDERSTANDING WITH THE OFFICE OF THE INSPECTOR GENERAL, DEPARTMENT OF LABOR, AND DIRECTED THOSE DIVISIONS TO CONDUCT THEIR INVESTIGATIVE MATTERS IN ACCORDANCE WITH THAT MEMORANDUM OF UNDERSTANDING.

THE DEPARTMENT OF LABOR IS CHARGED WITH BROAD REGULATORY AND ENFORCEMENT RESPONSIBILITY FOR ERISA. THE EXISTING MEMORANDA OF UNDERSTANDING BETWEEEN THE FBI AND THE OFFICE OF THE INSPECTOR GENERAL, ENSURE FBI COORDINATION OF ERISA MATTERS WITH THE DEPARTMENT OF LABOR, ALLOW FOR THE FBI'S NATIONAL PROGRAM MANAGEMENT PREVIOUSLY DESCRIBED, AND PROVIDE FOR

THE REFERRAL OF CASES, WHEN APPROPRIATE, AT THE FIELD OFFICE LEVEL.

PREVIOUSLY, WE HAVE BEEN ASKED FOR STATISTICAL INFORMATION CONCERNING MEWAS. IT WOULD BE EXTREMELY DIFFICULT FOR THE FBI TO RETRIEVE INFORMATION ON THE NUMBER OF MEWA CASES WHICH HAVE BEEN INVESTIGATED. THE RECORDING OF ACCOMPLISHMENTS BY THE FBI IS BASED UPON SUBSTANTIVE VIOLATIONS AND THE NAMES OF THOSE CONVICTED. IN THE CASE OF ERISA MATTERS, RETRIEVAL OF ACCURATE INFORMATION IS FURTHER COMPLICATED BY THE FREQUENT CONSOLIDATION OF THESE CASES INTO THE INVESTIGATIVE FILES ON ORGANIZED CRIME ENTERPRISES WHICH ARE CARRIED UNDER CASE CLASSIFICATIONS WHICH DO NOT REVEAL THE ERISA ASPECT. THE FBI'S WHITE COLLAR CRIMES PROGRAM HAS ENCOUNTERED AND AGGRESSIVELY INVESTIGATED ERISA VIOLATIONS AS PART OF LARGER FRAUD INVESTIGATIONS. BUT AGAIN, CASE MANAGEMENT WAS ACCOMPLISHED UNDER CASE CLASSIFICATIONS THAT IDENTIFY THE CASE AS A PARTICULAR FORM OF FRAUD. AN EXAMPLE IS THE MASSIVE RICO INVESTIGATION AND SUBSEQUENT CONVICTION OF MARIO RENDA, ET AL, DOING BUSINESS AS FIRST FUND. RENDA WAS INVOLVED IN THE NATIONWIDE BROKERING OF JUMBO CERTIFICATES OF DEPOSIT, HELD BY LABOR UNIONS, INTO FINANCIAL INSTITUTIONS. RENDA SKIMMED INTEREST PAYMENTS RIGHTFULLY BELONGING TO THE UNIONS AND PAID KICKBACKS TO UNION OFFICIALS FOR HIS INITIAL PLACEMENT OF THE CERTIFICATES OF DEPOSIT. RENDA ADDITIONALLY ARRANGED FOR BORROWERS TO OBTAIN LOANS FROM THE FINANCIAL INSTITUTIONS WHO ENJOYED THE INCREASED LIQUIDITY OFFERED BY THE UNION DEPOSITS.

THE FBI IN ITS WHITE COLLAR CRIMES PROGRAM HAS ALSO ENCOUNTERED ERISA VIOLATIONS WHILE CONDUCTING SECURITIES FRAUD INVESTIGATIONS. IN SEVERAL CASES CURRENTLY UNDER INVESTIGATION, EMPLOYEE STOCK OPTION PROGRAMS WERE MANIPULATED THROUGH MASSIVE SALES OF STOCK HELD BY CORPORATE INSIDERS. IN THESE CASES, CREATIVE ACCOUNTING OF CORPORATE EARNINGS IS USED TO EFFECT AN ARTIFICIAL INCREASE IN THE VALUATION OF THE COMPANY'S STOCK. AFTER THE INSIDERS LIQUIFY THEIR HOLDINGS AT THE INFLATED VALUE, THE MARKET PRICE OF THE STOCK DECREASES AND THE EMPLOYEE STOCK OPTION PROGRAM ABSORBS THE LOSS.

THE ABOVE CITATIONS DEMONSTRATE THE ROLE OF THE FBI WITH RESPECT TO ERISA MATTERS ADDRESSED UNDER THE FBI'S ORGANIZED CRIME NATIONAL STRATEGY, AND UNDER THE AUSPICES OF THE WHITE COLLAR CRIMES PROGRAM.

IN SUMMARY, THE IDENTIFICATION OF A BUSINESS STRUCTURE LIKE A MEWA IS OF STATISTICAL INTEREST TO AN AGENCY, SUCH AS THE DEPARTMENT OF LABOR, WITH REGULATORY RESPONSIBILITY OVER THAT ENTITY. IN THE EVENT THAT A CRIME PROBLEM OUTSTRIPS A REGULATORY MECHANISM, LOGICAL REMEDIES TO THE PROBLEM MUST BE SOUGHT WITHIN PARAMETERS ESTABLISHED BY THE INVESTIGATIVE AND REGULATORY AGENCIES. THE FBI, AN INVESTIGATIVE AGENCY WITHOUT A REGULATORY PERSPECTIVE ON THIS ISSUE, IS NOT AWARE OF ANY QUANTITATIVE OR QUALITATIVE ANALYSIS OF A CRIME PROBLEM IN THIS AREA. AS PREVIOUSLY STATED, OUR INTELLIGENCE BASE DOES NOT INDICATE THAT MEWAS HAVE BEEN SOLELY OR SELECTIVELY TARGETED BY ORGANIZED CRIME. WE RELY ON DEFINED PROCEDURES FOR OPENING INVESTIGATIVE

MATTERS BASED UPON PROGRAM PRIORITIES ESTABLISHED THROUGH AREA AND NATIONAL ASSESSMENT OF CRIME PROBLEMS BY FBI MANAGERS. THE ASSESSMENTS INCLUDE INPUT FROM LOCAL, STATE, AND OTHER FEDERAL AGENCIES AS WELL AS THE EVALUATION OF THE AREA UNITED STATES ATTORNEY. THROUGH THE ESTABLISHMENT OF THESE STANDARDS, THE FBI AND THE OFFICES OF THE UNITED STATES ATTORNEY, ENSURE THAT NATIONAL PROGRAM PRIORITIES ARE MET, THAT PROSECUTIVE STANDARDS ARE SATISFIED, AND THAT OUR RESOURCES ARE UTILIZED EFFICIENTLY AND EFFECTIVELY.

THIS CONCLUDES MY STATEMENT. IF THERE ARE ANY QUESTIONS, I WILL BE HAPPY TO ENTERTAIN THEM AT THIS TIME.

STATEMENT OF
RAYMOND MARIA
DEPUTY INSPECTOR GENERAL
U.S. DEPARTMENT OF LABOR
BEFORE THE PERMANENT SUBCOMMITTEE ON INVESTIGATIONS
COMMITTEE ON GOVERNMENTAL AFFAIRS
UNITED STATES SENATE
MAY 15, 1990

Chairman Nunn and Members of the Subcommittee,

It is indeed a pleasure to appear before this Subcommittee. During the past nine months, I have testified numerous times before various Congressional Committees regarding the enforcement strategy of the Department of Labor (DOL), particularly with respect to pension and welfare benefit plan enforcement, and the intertwined subject of the investigative authority of the Office of Inspector General (OIG).

In all honesty, these issues have not always been completely familiar ones for some of these Committees. However, I know this Subcommittee, and particularly its Chairman, is acutely aware of these issues, and very knowledgeable with regard to them, due to prior PSI hearings and reports.

For example, due to PSI's efforts and interest, the Comprehensive Crime Control Act of 1984 included a provision which amended ERISA and practically demanded that the Secretary of Labor increase the Department's criminal enforcement activities. Unfortunately, the Secretary has not heeded the intentions of Congress.

In fact, Mr. Chairman, it is clear that with the exception of the Office of Inspector General, very little, if anything, has changed at the Department of Labor with regard to criminal enforcement in all of the years in which PSI has maintained its interest in this subject. There is still an undue reliance on civil and administrative enforcement and a strong institutional reluctance to vigorously employ criminal remedies.

This reluctance has an even greater impact right now due to the March, 1989 Department of Justice (DOJ) legal opinion which restricted the investigative authority of all Inspectors General. This opinion, which was requested by the Solicitor of Labor in order to affirm his own internal advice to the Secretary, has left the criminal enforcement of many DOL programs in the exclusive hands of the Department's program personnel. By and large, Mr. Chairman, the programs simply do not have the necessary independence, the necessary expertise, nor the necessary motivation to conduct effective criminal fraud investigations.

Unfortunately, the investigations of most fraudulent self-funded multiple employer welfare arrangements (MEWAs) fall into this category. Although the previous witnesses have accurately and in some cases dramatically described the extent of the self-funded MEWA problem, several additional comments are warranted.

Fraudulent MEWAs are a pernicious problem because they not only create tragic consequences for subscribing employers and participants by leaving them liable for unpaid medical bills, but in some instances they also leave participants with "pre-existing" conditions for which they will never be insured in the future. Further, these consequences are much more likely to affect individuals on the lower end of the socio-economic scale, individuals who truly need government regulation and intervention to protect their rights.

It is virtually impossible to accurately determine the extent of the MEWA problem or the number of fraudulent MEWAs in operation. However, I can assure this Subcommittee that many more States than the ones represented here this morning have encountered these same problems and difficulties, because these States have contacted OIG looking for some type of enforcement assistance.

Vigorous criminal enforcement is needed to address fraudulent MEWAs because we are not dealing with technical nor accidental violations of statutory and regulatory provisions, but with intentional and flagrant criminal conduct. State insurance officials simply are not equipped to effectively deal with these schemes in which racketeers and money move quickly from state to state and in some cases to off-shore accounts.

The people committing MEWA-related frauds are professional thieves, people for whom civil fines are merely a cost of doing business, people who move from one fraudulent MEWA to another, people who have experience in penny stock frauds and other types of boiler room sales operations. These are people right out of the Fountain Pen Conspiracy of the 1970s. In fact, one individual currently under investigation by OIG for MEWA-related fraud is mentioned in this very book.

But, in responding to calls for help from State officials, OIG has had one hand tied behind its back, because the Department of Justice legal opinion prohibits us from fully utilizing our investigative resources. Can State officials rely upon DOL's Pension and Welfare Benefits Administration (PWBA) for needed criminal investigative support? I submit the answer is no, based upon PWBA's track record as well as its enforcement strategy and procedures.

Contrary to popular belief, the MEWA problem is not a completely new one. In 1982, the House Committee on Education and Labor held a hearing very much like today's hearing, wherein individuals victimized by fraudulent MEWAs described their traumatic circumstances and State officials testified that both additional regulation and increased criminal enforcement was needed.

Since that time, how many criminal indictments of MEWA operators have been obtained by PWBA? I am not aware of any. Although the Assistant Secretary for Pension and Welfare Benefits says that PWBA has 40 ongoing civil and criminal investigations, the true barometer will be how many of these investigations culminate in criminal indictments. Again, I would bet that the answer will be very, very few, if any.

PWBA believes ERISA is primarily a "civil" statute where penalties should be limited to restitution and a promise not to do it again. This is the insitutional reluctance which I mentioned earlier. But with respect to pension and welfare benefit plans, this belief has been consistently refuted by Congress, including the Chairman of this Subcommittee during and following the passage of the 1984 Crime Control Act amendment to ERISA.

PWBA's position is just plain bad government policy. Only criminal remedies will deter criminal conduct, and with the imposition of the Federal sentencing guidelines, jail is a real possibility for those who commit benefit plan fraud.

In addition, criminal penalties can include forfeiture of assets, with no arguments nor negotiations about appropriate restitution, as well as disqualification from any benefit plan related positions for thirteen years, a sanction which this Subcommittee supported and fought for in 1984. Within DOL, only the Office of Inspector General has utilized this important sanction, and in 1988 we obtained the only criminal conviction of an individual for holding a prohibited position.

Even if PWBA wished to change its civil emphasis, it does not have, unlike OIG, any professionally trained and recognized ("GS-1811") criminal investigators, people who know where to look and how to look for criminal activity -- Special Agents who are adept at using standard investigative techniques such as electronic surveillance, search warrants, undercover operations, and the development of informants and other confidential sources.

The Assistant Secretary for Pension and Welfare Benefits can extol his new and improved "targeted" or "significant issues" enforcement strategy, which relies upon reviewing 5500 Forms to obtain investigative leads, as much as he likes, but I can assure you that significant benefit plan fraud will not be detected through a review of 5500 Forms, no matter how automated or sophisticated that review is.

Simply put, with a policy that relies upon civil redress and a staff which has no professional criminal investigators, PWBA is institutionally incapable of recognizing flagrant fact patterns and conceptualizing all potential criminal offenses which may be applicable. I believe a classic example of this deficiency occurred when the Secretary of Labor, following a PWBA investigation, recently filed a civil suit in Texas against the administrator of a chemical supplier's pension plans.

PWBA's press release alleges a conflict of interest by the administrator when he took $1 million in pension plan money in the form of loans to himself and a business partner, and lent pension funds to others to invest in businesses in which he had an interest. As a result of these loans the administrator allegedly concentrated plan assets in cattle investment programs in violation of ERISA's diversification rules.

The dollar amounts involved in this case and the basic fact pattern described in PWBA's press release cry out for criminal investigation, but PWBA has failed to recognize, let alone aggressively pursue this avenue. OIG, after meeting with the United States Attorney in Houston, has begun a criminal investigation of this matter. The initial allegations present a stark contrast to the PWBA press release. They depict outright concealment and embezzlement of plan assets for the administrator's personal benefit.

In addition, we have learned that these were defined contribution pension plans and therefore not insured by the Pension Benefit Guaranty Corporation (PBGC), that false documents were provided to plan participants, and that false 5500 Forms were submitted to the Department of Labor and the Internal Revenue Service. Again, this illustrates the folly of using 5500 Forms to generate leads related to significant criminal fraud--crooks do not file truthful forms.

If the situation which I have just described involved a Taft-Hartley fiduciary, I can guarantee that he or she would be facing the risk of serious criminal charges and possible jail time. But for PWBA, this is only an example of a general failure to grasp and deal with blatant fraud -- acts which clearly cross well over the line of imprudent business transactions.

This example also illustrates a key distinction between PWBA's criminal enforcement procedures and OIG's procedures. We go to the United States Attorneys at the beginning of an investigation and work with the U.S. Attorneys throughout the investigation. We want to make sure there is prosecutorial interest and we want to make sure that prosecutorial decisions are made by prosecutors, not by untrained and, perhaps, unobjective program personnel.

This Subcommittee has implored the Department of Labor for years to employ criminal remedies against those who defraud American workers. For labor racketeering matters, this Sub- committee made sure that a labor racketeering function was established in OIG when the IG Act was passed in 1978 to ensure independent and objective criminal investigations of labor racketeering matters. The Office of Labor Racketeering (OLR) has carried out this function with distinction, contributing to over 750 convictions during the past twelve years, including over 300 benefit plan related convictions.

Between 1978 & 1990, the definition of "labor racketeering" has evolved as it relates to OIG jurisdiction. Labor racketeering should not be restricted to union trustees and traditional "organized crime" groups. Corruption, particularly in pension & welfare plans, has become the province of new "racketeering" groups comprised of attorneys, accountants, service providers, bankers, insurance agents, and other "white collar" individuals.

But for matters not falling within OLR's jurisdiction, including most MEWA cases, OIG has been thrown out of the game by the DOJ opinion and, as a result, the enforcement playing field is tilted. Labor and management benefit plan trustees and others associated with Taft-Hartley plans are at risk of detection and investigation by OLR if they are engaged in criminal conduct.

But individuals associated with non-Taft-Hartley plans, which are often single employer plans and MEWA-related plans, are largely immune from scrutiny. This draws perilously close to a double standard of justice.

OIG, by using its Office of Labor Racketeering jurisdiction, which is not affected by the DOJ opinion, has opened approximately 24 MEWA investigations. Thus far, one indictment has been obtained, in Atlanta, in United States v. Buccheri, et al. In this case, a joint investigation involving OLR and other Federal and State law enforcement agencies resulted in an indictment charging three operators of a MEWA and a union official with embezzlement and making and receiving kickbacks. The MEWA in question allegedly provided health benefits to approximately 9,000 employees and dependents with nearly 300 companies in 16 different States. Unpaid medical claims exceeded $800,000.

It is naive to believe that State law enforcement and/or insurance officials could conduct the same investigation. It is probably just as foolish to believe that PWBA could, or would, conduct the same investigation.

Assistant Secretary Ball has made it clear that fraudulent MEWAs are basically a State rather than Federal problem since the States normally regulate insurance operations and they are in virtually all instances not restricted by ERISA's preemption rules. Although this may be true in theory, it falls apart completely in practice. How can the State of Georgia recover premiums or institute criminal proceedings when the MEWA operators in Atlanta have moved to North Carolina, or California, or New York? How can a cease and desist order be effective when it cannot be served? How can restitution be obtained when premiums have already been spent by MEWA operators, perhaps for cars, boats, and other big ticket items. This is precisely why Mr. Ball's strategy is ill-conceived and why Federal intervention in the form of aggressive criminal enforcement is necessary, and OIG has accepted this challenge.

More indictments from OLR investigations are forthcoming, as I continue to detail some agents from OIG's Office of Investigations to OLR in order to pursue MEWA fraud under OLR's jurisdiction. But even more could be done, perhaps a doubling or even tripling of MEWA investigations, if OIG were not restricted to using only its labor racketeering jurisdiction.

Therefore, I strongly urge all Members of this Subcommittee to support the legislation which has just been introduced by Senator Glenn which would clarify the investigative authority of the IGs and nullify the effects of the DOJ opinion. An identical bill has also been introduced in the House by Representative Conte. The reasons which are advanced for denying this authority to the IGs are outweighed, indeed they are dwarfed, by the need for additional criminal enforcement in regulatory and other programs in all Federal agencies.

The Inspector General at the Department of Health and Human Services has had to discontinue his investigations of fraud in the generic drug industry and in other areas regulated by the Food and Drug Administration.

The Inspector General at the Department of Interior has had to curtail major investigations of fraud related to the payment of Outer Continental Shelf oil and gas royalties.

The Inspector General at the State Department has had to stop the majority of his investigations related to passport and visa fraud.

Within the Department of Labor, investigations affected by the DOJ opinion include not only fraudulent MEWAs and other benefit plans, but investigations of fraud and abuse related to workplace safety and health, and investigations related to wage and hour violations.

With this background in mind, let me make clear OIG's position and intentions with respect to its investigative authority. OIG's investigative components, whether investigating MEWAs or other employee benefit plans, the actions of DOL employees, the operation of the Job Training Partnership Act, payments under the Federal Employee Compensation Act, or any other subject related to DOL programs and operations, are interested in the detection and prevention of fraud, which is exactly what Congress intended when it passed the Inspector General Act of 1978.

OIG's investigators do not focus on compliance with regulatory requirements but on the detection of criminal fraud, embezzlement, and theft. OIG is not interested in making program policy or engaging in any other "program operating responsibilties," and neither OIG nor any other Inspector General has, to my knowledge, ever trespassed into these areas.

Contrary to the assertions made by some who are opposed to OIG investigations of MEWAs and benefit plans in general, OIG does not wish to become a super police force. In reality, the number of additional investigations which OIG could conduct if not restricted by the DOJ opinion is limited by budget and other restraints. Perhaps OIG, through its Office of Investigations, could conduct 10-15 successful investigations per year related to welfare plan fraud.

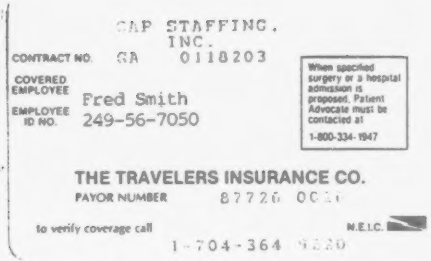
But these would be, I am certain, significant investigations involving egregious conduct, multiple defendants, and multi-state scams, and the deterrent effect of these investigations would go far beyond the cases themselves. It is exceedingly difficult for me to accept the position that PWBA's program responsibilities and/or overall investigative strategies would be threatened or harmed in any fashion by this limited number of OIG investigations. This contention is both speculative and spurious.

American workers deserve nothing less than the full protection of the laws designed to protect their pension and welfare benefits, make their workplaces safe, and ensure that they receive minimum wages and fringe benefits. This is what OIG has attempted to do and what OIG will continue to do.

I would be pleased to answer any questions you may have.

Senate Permanent Subcommittee
on Investigations

EXHIBIT # 1



CAP STAFFING, INC.

CONTRACT NO. GA 0118203

COVERED EMPLOYEE Fred Smith

EMPLOYEE ID NO. 249-56-7050

When specified surgery or a hospital admission is proposed, Patient Advocate must be contacted at

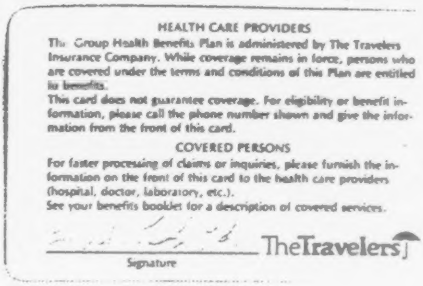
1-800-334-1947

THE TRAVELERS INSURANCE CO.

PAYOR NUMBER 87726 OC[illegible]

to verify coverage call 1-704-364 [illegible]

N.E.I.C.



HEALTH CARE PROVIDERS

The Group Health Benefits Plan is administered by The Travelers Insurance Company. While coverage remains in force, persons who are covered under the terms and conditions of this Plan are entitled to benefits.

This card does not guarantee coverage. For eligibility or benefit information, please call the phone number shown and give the information from the front of this card.

COVERED PERSONS

For faster processing of claims or inquiries, please furnish the information on the front of this card to the health care providers (hospital, doctor, laboratory, etc.).

See your benefits booklet for a description of covered services.

Signature

TheTravelers

Senate Permanent Subcommittee
on Investigations

EXHIBIT # 5

# AFFIDAVIT

OF

JOAN MARIE SELF

I, Joan Marie Self, residing at 100 Peachtree Court, Matthews, North Carolina, Union County, presently employed at Republic Insurance Company, Charlotte, North Carolina, state that the following information is true and correct to the best of my knowledge and recollection.

I was employed with CAP STAFFING, INC., 6407 Idlewild Road, Suite 201, Charlotte, North Carolina, from the end of September, 1988, until March 15, 1989. My job title changed several times during the course of my employment.

From the end of September, 1988, until approximately the middle of October, 1988, I was the receptionist. CAP STAFFING was just forming at this time.

During the month of October, 1988, I was instructed to mail out letters to all CAP PROGRAM, INC., investors telling them about the medical insurance available through CAP STAFFING. (I was under the impression, along with all other employees, salespeople, and clients, that Travelers was the carrier of this medical insurance since Harold Pyles, of Travelers, was in frequent contact with Ron Harris; plus all deck sheets for the brochures, along with the brochures, and all enrollment cards had Travelers on them. I made several trips to the Travelers office in Charlotte to pick up enrollment cards for CAP STAFFING.) Although the investors weren't employed by CAP STAFFING, they were still eligible for the medical insurance due to their assocation with CAP PROGRAMS. At that time, individual coverage for medical was $42.50 and family coverage was $152.90; plus an addition fee for dental and vision. A Travelers insurance enrollment card was enclosed in each letter with instructions to send it back to me, with the first two months premium by November 1, 1988, when the insurance went into effect.

During the first part of November, 1988, Jerry Wolicki, Bob Long, and Ron Harris decided to give me the responsibility of handling the insurance program. Ron Harris was suppose to train me for this job, but never did. Not long after I took on this responsibility, Ron Harris took me to a meeting at Professional Employees, Inc., with Joy Coble. He was trying to persuade her to put all of her employees on CAP STAFFING'S medical insurance program. He stated that CAP STAFFING would not have enough enrollees without her employees and this program would be exactly the same as her plan in existence that included disability.

Approximately the middle of November, 1988, I was given the company checkbook along with the responsibilities of Accounts Payable, Accounts Receivable, Payroll deposits, tax deposits, and all other deposits for the company. At that time, CAP STAFFING had two accounts with Wachovia Bank; the working account and the payroll account. I deposited all payments received in the working account and would transfer over to the payroll account as needed. There was no money set aside, or no special account for insurance at this time.

Late November, 1988, I had to set up billing for the insurance for Administrative Service Clients (Administrative Services included lawyers, labor dispute experts, etc.). With these services, a client was eligible for the insurance. The charge for this was billed at the same time the client was billed for the insurance. The charge was $10.00 per person per month. With the bigger clients, they had a flat fee which varied from client to client. The payments received from these clients went into the CAP STAFFING working account.

Approximately the middle or end of November, 1988, Harold Pyles, from Travelers, called to request a payment from CAP STAFFING for a binder. The amount was a large sum that CAP STAFFING did not have. The next day, Ron Harris and Bob Long flew to Hartford, CT, to meet with the officers of Travelers. Monday, when they returned to the office, all I was told was that everything had been taken care of. I was not informed that we were now a self-insured program. It was not long after this that Ron Harris and Bob Long started changing the premiums.

I believe it was in December, 1988, when Bob Long started having me write checks out of CAP STAFFING working account to CAP PROGRAMS. This money was used to pay investors who were either requesting their investment money or their monthly interest payments.

By the middle of December, CAP STAFFING had so many clients on Administrative Services that it took at least one entire day to bill all of them. I still did not know that we were self-insured. I did not find out about this until the first of the year when we received a bank statement from another account other than with Wachovia. It was then that Ron Harris told me this was the claims account for Travelers. He did not explain why we had a claims account until later. Between what Ron Harris, Bob Long, and Harold Pyles told me, I was able to figure out what self-insured meant and that we were to deposit $11,000 a week into the claims account. When I left the company on March 15, 1989, we may have made one deposit. In fact, there was one occasion when we did not have enough money to meet payroll and Ron Harris wrote a check from the claims account to CAP STAFFING working account to cover the payroll.

Whenever I questioned Ron Harris about the balance of this claims account and the required amount we should be depositing, he would inform me that we only needed to keep a balance of $11,000 in this account. Once when I tried to make a deposit to the claims account, to cover the check that Ron Harris had wrote to cover payroll and an additional amount, Bob Long had me void the deposit and give half of the money to CAP PROGRAMS. When I questioned this, I was told not to worry about it, it was his company.

By February, 1989, Bob Long was having me transfer money to CAP PROGRAMS so often, that I had to meet payroll, payroll taxes, and accounts payable before Bob found out the balance of the working acocunt.

Around the end of February, CAP STAFFING hired three people. One to handle the insurance program, one to handle the CAP PROGRAM investors, and one accountant. At this time, Jerry Wolicki, informed me that Bob Long was going to turn my responsibilities over to these individuals. Before this happened, Jerry Wolicki had me pay off his credit cards. I never received an explanation of the charges such as a statement, just the payment stub from the statement to send with each payment. I made two individual payments of $3,000 and $3,500 each before turning over the books to the new accountant. Jerry Wolicki said all the charges were CAP STAFFING, but the card and the bill were made out to Jerry Wolicki, not CAP STAFFING, INC.

The first week of March, 1989, I turned in my resignation. Jerry Wolicki told me he was going to start his own employee leasing company and wanted me to work for him. It was about a week after I left the company that I realized what Jerry had done.

During the entire time I was employed with CAP STAFFING the normal business day started with Bob Long and Ron Harris in the office until 10-11:00 A.M. They would then leave for lunch and very rarely came back. If we had to reach them, we would call either Lanny's restaurant or Grady's restaurant in Charlotte. Both places have a bar or lounge were Bob and Ron spent their afternoons. Ron Harris would sometimes come into the office first thing in the morning and had already been drinking. It was very hard to work under those conditions and it's even harder to run a successful company under those conditions.

This concludes my summary of the events that occured during my employment with CAP STAFFING, INC.

I do certify that the above is true to the best of my knowledge and recollection, this 10th day of May, 1990.

Joan Marie Self
Joan Marie Self

State of North Carolina
County of Mecklenburg

On this 10th day of May, 1990, personally appeared Joan Marie Self and acknowledged the above instrument by her executed to be her free act and deed.

Ann K. Henley
My comm. expires 7-6-90

Senate Permanent Subcommittee
on Investigations
EXHIBIT # 7

UNITED STATES SENATE

PERMANENT SUBCOMMITTEE ON INVESTIGATIONS

STATEMENT FOR THE RECORD BY LAWRENCE A. LADDAGA, ESQUIRE

FRAUD & ABUSE IN EMPLOYER HEALTH BENEFIT PLANS

TUESDAY, MAY 15, 1990

LAWRENCE A. LADDAGA
**ATTORNEY AND COUNSELOR AT LAW**
145 King Street, Suite 317
Post Office Box 1234
Charleston, South Carolina 29402

Telephone (803) 723-8343

May 4, 1990

RECEIVED BY
SENATE PERMANENT
SUBCOMM ON INVESTIGATIONS
MAY 08 1990
[illegible] OFFICE

The Honorable Sam Nunn
Chairman, United States Senate
Permanent Subcommittee on Investigations
Washington, D. C. 20510

Attention: Mr. David Buckley
Chief Investigator

Re: ERISA

Dear Mr. Buckley:

Enclosed please find a copy of our Complaint in the matter of Roper Hospital v. Travelers Insurance and Fred L. Smith, Civil Action No. 2:90-697-1, which is a matter of public record.

Let me also take this opportunity to express my personal opinion that the trend of Court decisions this decade has seriously undermined ERISA's purpose to protect beneficiaries and plan participants.

First let me say that 75% of my practice is in the commercial law area, primarily, in collecting unpaid accounts for hospitals. I represent some fourteen providers in the State, but I am not writing to you on their behalf or at their request, but am writing to you as an attorney and consumer.

Insurance companies' use of ERISA to pre-empt State law causes of action for breach of contract, bad faith and others, combined with the Federal Court's reluctance to apply common law principles to ERISA matters, has made it very difficult for plan beneficiaries to enforce their rights, as well as some sense of fairness and equity in these matters.

As one small example of this dilemma, consider the issue of oral representations. It is reasonable to argue that the majority of communications between an individual employee or plan beneficiary and his employer will be oral communications, either face-to-face or telephonically. Likewise, when a hospital accepts an assignment of benefits from a potential patient, they call the employer, plan administrator or insurance company, as the beneficiary, requesting a certification of benefits and coverage. If those representations turn out to be false, any State law causes of action against the employer, plan administrator or insurance company are pre-empted by ERISA. Upon filing removal to Federal Court, the plans take the position that they are not bound by oral representations. In order to avoid unnecessarily lengthening this correspondence, I have obtained permission from my client to transmit to you some matters of public record in the case of Baker Hospital v. Aetna, Civil Action No. 2:88-2670-8, which are Defendant, Aetna Insurance Company's, Motion for Summary Judgment; my response in opposition to the Motion for Summary Judgment; the Master's Report Recommending Summary Judgment; and our Notice of Objections to the Master's Report.

Simply stated, if State law causes of action for oral misrepresentations are pre-empted by ERISA, and if ERISA precludes any liability for those misrepresentations, then the current state of Federal laws is that employers and/or plan administrators and/or insurance companies may in fact lie to employees and plan beneficiaries as long as such lying is done orally and not in writing.

It is incongruous to me that a statute designed to protect beneficiaries can apparently perform so well in the area of pension benefits, yet perform so poorly in regards to health benefits.

If you need any further information or assistance, please do not hesitate to call.

Thanking you for the opportunity to provide my opinion, and with best regards, I am

Sincerely,

Lawrence A. Laddaga

LAL:df
Enclosures
cc: Ms. Suzanne Hogsett, Baker Hospital
Mr. Brian Graham, Roper Hospital

IN THE UNITED STATES DISTRICT COURT
DISTRICT OF SOUTH CAROLINA
CHARLESTON DIVISION

RIGINAL FILED
APR 2 1990
ANN A. BIRCH, CLERK
CHARLESTON, S. C.

ROPER HOSPITAL,
Plaintiff,
-versus-
THE TRAVELERS COMPANIES AND FRED L. SMITH,
Defendants.

C. A. NO: 2 90 0697 1

COMPLAINT

NON-JURY/ERISA ACTION

**FOR A FIRST CAUSE OF ACTION-ERISA-FAILURE TO PAY BENEFITS**

The Plaintiff comes now before this Honorable Court and respectfully alleges as follows:

1. That the Plaintiff is a corporation duly organized under the laws of the State of South Carolina, having its principal place of business in Charleston County, South Carolina, engaged in the provision of health care as a hospital under applicable South Carolina State laws and regulations.

2. That upon information and belief, the Defendant, The Travelers Companies, (hereinafter "Travelers") is an insurance company with its principal place of business with regard to this claim, in Charlotte, North Carolina, and is authorized to do business in the State of South Carolina.

3. That the Defendant, Fred L. Smith is a citizen and resident of the County of Charleston, State of South Carolina.

4. That jurisdiction of this Court is invoked pursuant to 29 U.S.C. Section 1001, et. seq., and this is a claim for benefits pursuant to 29 U.S.C. Section 1132 (a) (1).

5. That on or about July 10, 1989, the Defendant Fred L. Smith was admitted to the Plaintiff's facility for the purpose of receiving medical treatment, as is evidenced by Exhibit "A" attached hereto, and incorporated herein by reference.

6. That the Defendant Fred L. Smith represented that he was entitled to insurance benefits through his employer, Cap Staffing, Inc. and the Defendant Travelers, and assigned his benefits to the Plaintiff, such that Plaintiff has acquired Smith's rights under said policy.

7. That on January 12, 1989, the Plaintiff Roper Hospital, by and through its employee, Marsha Gonzales, telephoned the Defendant Travelers, and spoke with its agent, servant, or employee, Beverly, to obtain a certification of benefits on the above stated admission of the Defendant Fred L. Smith, in order to determine his eligibility for admission to the Plaintiff's facility.

8. That the Defendant Travelers, by and through its agent, servant or employee, Beverly, represented to the Plaintiff that an assignable policy was in effect with coverage as follows:

A $100 deductible had to be met; 80% of the charges for a semi-private room and board would be paid; 80% of miscellaneous charges would be paid; that the OOP total was

$1,000.00; and that precertification was required.

9. Based upon this certification, the Plaintiff admitted the Defendant Fred L. Smith, to its facility where he was treated from July 10, 1989 through August 9, 1989, and incurred a bill in the amount of Thirty Seven Thousand Three Hundred Fifty Seven and 10/100 ($37,357.10) Dollars, a copy of which is attached hereto as Exhibit "B".

10. That the Plaintiff submitted its bill to the Defendant Travelers for payment. The Plaintiff to date has not received payment on this account, pursuant to the above mentioned certification of benefits provided the Plaintiff by the Defendant Travelers, by and through its agent, servant or employee, Beverly, and the Plaintiff is informed and believes that it is appropriate under the written terms of said plan. Therefore, a balance of Thirty Seven Thousand Three Hundred Fifty Seven and 10/100 ($37,357.10) Dollars is due and owing to the Plaintiff for its services to date.

11. That Plaintiff is informed and believes that the Defendant Travelers provides verification of coverage on a regular and routine basis to providers without appropriate investigation and/or review, in violation of 29 U.S.C. Section 1102 (a) (1), which requires that the Plan be maintained in writing.

12. That the Defendant Travelers is indebted to the Plaintiff in the amount of Thirty Seven Thousand Three Hundred Fifty Seven and 10/100 ($37,357.10) Dollars.

13. That the Plaintiff Roper Hospital, believes that it

should be entitled to the recovery of reasonable attorney's fees in this matter.

14. That the Plaintiff Roper Hospital has been damaged in the amount of Thirty Seven Thousand Three Hundred Fifty Seven and 10/100 ($37,357.10) Dollars.

## FOR A SECOND CAUSE OF ACTION-BREACH OF FIDUCIARY DUTY

15. That the allegations of Paragraphs 1 through 14 are repeated, realleged, and reiterated, as if fully set forth herein verbatim.

16. That at all times herein, the Defendant Travelers was acting as the fiduciary, co-fiduciary, or as agent for the same.

17. That the Defendant Travelers' procedures for verification of benefits and/or verification of coverage constitutes a breach of fiduciary duty, in violation of Section 1104 (a) (1) (A) and (B).

18. That the Plaintiff Roper Hospital has been damaged in the amount of Thirty Seven Thousand Three Hundred Fifty Seven and 10/100 ($37,357.10) Dollars.

## FOR A THIRD CAUSE OF ACTION-BREACH OF CONTRACT-
## AS AGAINST FRED L. SMITH

19. That the allegations of Paragraphs 1 through 18 are repeated, realleged and reiterated, as if fully set forth herein verbatim.

20. That the Defendant Fred L. Smith was admitted to the Plaintiff's facility, on or about July 10, 1989 and received treatment, which is evidenced by Exhibit "A" attached hereto

and incorporated herein by reference.

21. That the Defendant Fred L. Smith incurred medical expenses and bills in the amount of Thirty Seven Thousand Three Hundred Fifty Seven and 10/100 ($37,357.10) Dollars, as will more fully appear from the detailed bill attached hereto and incorporated herein as Exhibit "B".

22. That an implied contract for payment arises out of the above mentioned admission and treatment.

23. That the Plaintiff has made due demand for payment and that payment has not been received from this Defendant.

24. That there is due and owing to the Plaintiff, the sum of Thirty Seven Thousand Three Hundred Fifty Seven and 10/100 ($37,357.10) Dollars.

WHEREFORE, Plaintiff demands judgment against the Defendants The Travelers Companies and Fred L. Smith in the total amount of Thirty Seven Thousand Three Hundred Fifty Seven and 10/100 ($37,357.10) Dollars, together with reasonable attorney's fees, the costs and disbursements of this action, and for such other and further relief as this Court may deem just and proper.

LAWRENCE A. LADDAGA (I.D.# 2579)
145 King Street, Suite 317
Post Office Box 1234
Charleston, SC 29402
(803) 723-8343
ATTORNEY FOR PLAINTIFF

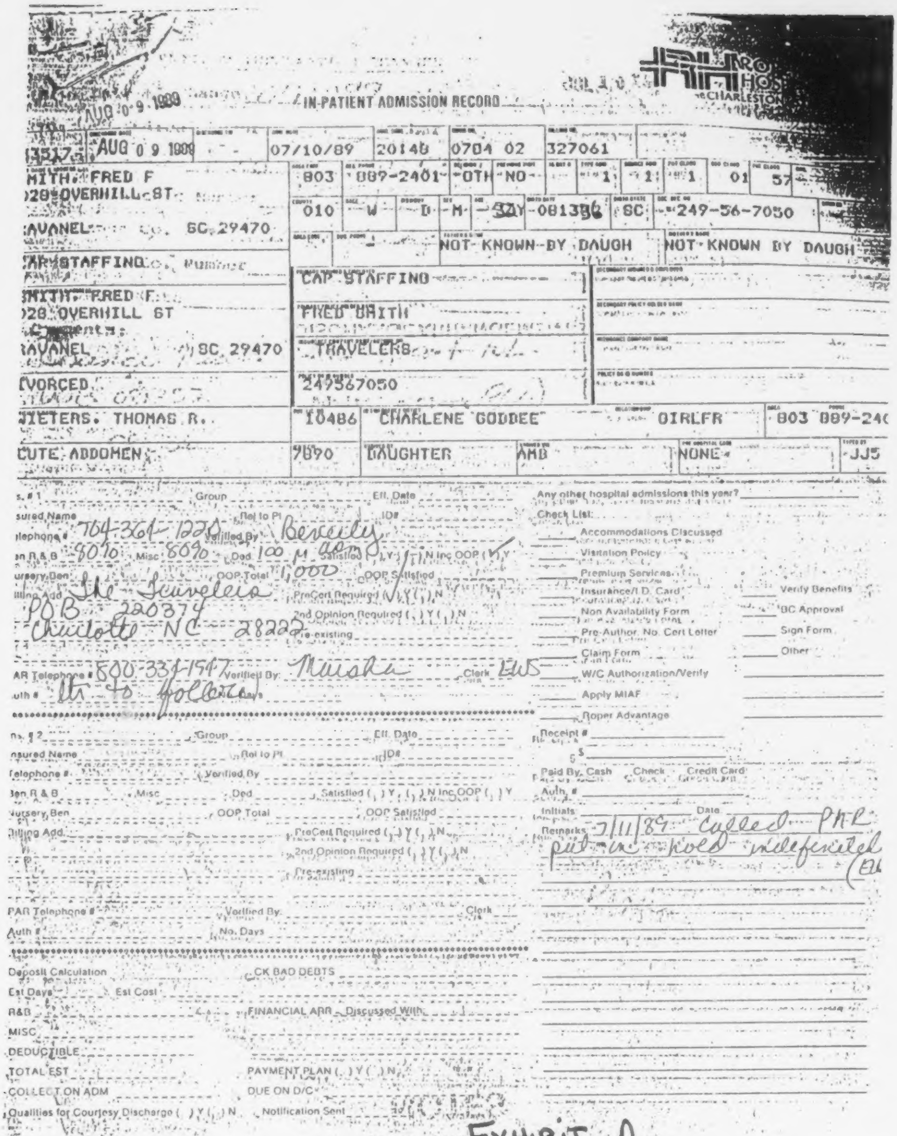
Charleston, South Carolina.
Dated: 3/13/90

STATE OF SOUTH CAROLINA )
) VERIFICATION OF ACCOUNT
COUNTY OF CHARLESTON )

PERSONALLY appeared before me Robert N. Cox, who being duly sworn, deposes and states that he is the Director of Patient Fiscal Services of Roper Hospital and as such he has been authorized to sign this Verification of Account, stating that Fred L. Smith was treated at Roper Hospital on July 10, 1989 through August 9, 1989, incurring the within referenced medical bill attached hereto as Exhibit "B", in the total amount of Thirty Seven Thousand Three Hundred Fifty Seven and 10/100 ($37,357.10) Dollars.

Robert N. Cox
Robert N. Cox

Sworn to before me this 8th
day of March, 1990.
Lucia S. Hall.
Notary Public for South Carolina
My Commission Expires: My Commission Expires October 19, 1997



AUG 0 9 1989

IN-PATIENT ADMISSION RECORD

ROPER HOSPITAL CHARLESTON

| | | | | | | |
|---|---|---|---|---|---|---|
| 3517 | AUG 0 9 1989 | | 07/10/89 | 20148 | 0704 02 | 327061 |

MITH, FRED F
028 OVERHILL ST
AVANEL SC 29470

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 803 | 889-2401 | OTH | NO | | 1 | 1 | 1 | 01 | 57 |
| 010 | W | D | M | 32Y | 081356 | SC | 249-56-7050 | | |

NOT KNOWN BY DAUGH
NOT KNOWN BY DAUGH

AR STAFFING
CAP STAFFING

SMITH, FRED F
028 OVERHILL ST
AVANEL SC 29470
FRED SMITH
TRAVELERS
IVORCED
249567050

IETERS, THOMAS R.
10486
CHARLENE GODDEE
GIRLFR
803 889-24

CUTE ABDOMEN
7890
DAUGHTER
AMB
NONE
JJ5

s. # 1 Group Eff. Date
sured Name Rel to Pt ID#
elephone # 704-361-1220 Verified By Beverly
en R & B 80% Misc 80% Ded 100 m 4om Satisfied ( ) Y (✓) N Inc OOP (✓) Y
ursery Ben OOP Total 1,000 OOP Satisfied
illing Add The Travelers ProCert Required (✓) Y ( ) N
POB 220374 2nd Opinion Required ( ) Y ( ) N
Charlotte NC 28222 Pre-existing
AR Telephone # 800-331-1947 Verified By: Marsha Clerk EWS
uth # ltr to follow

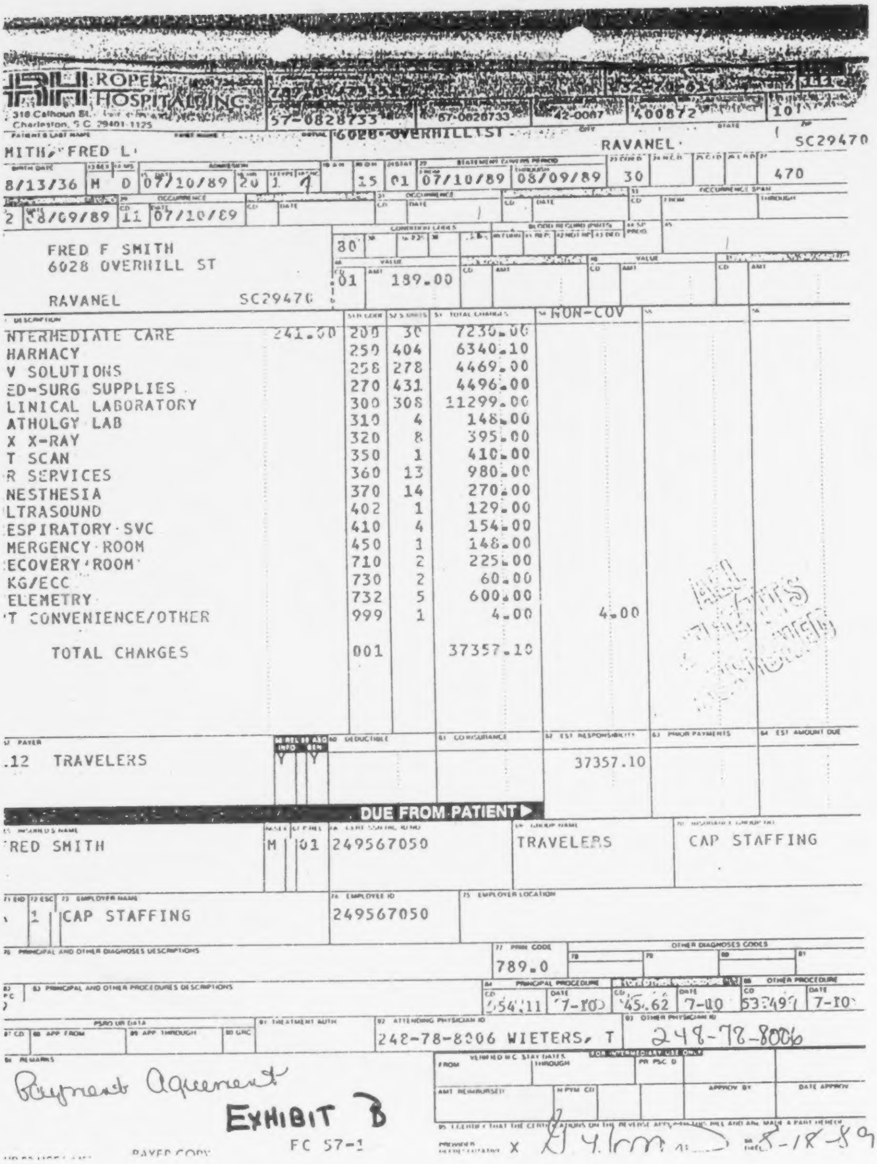
Any other hospital admissions this year?
Check List:
Accommodations Discussed
Visitation Policy
Premium Services
Insurance/I.D. Card
Non Availability Form
Pre-Author. No. Cert Letter
Claim Form
W/C Authorization/Verify
Apply MIAF
Roper Advantage
Verify Benefits
BC Approval
Sign Form
Other

ns. # 2 Group Eff. Date
nsured Name Rel to Pt ID#
Telephone # Verified By
Ben R & B Misc Ded Satisfied ( ) Y ( ) N Inc OOP ( ) Y
Nursery Ben OOP Total OOP Satisfied
Billing Add. ProCert Required ( ) Y ( ) N
2nd Opinion Required ( ) Y ( ) N
Pre-existing
PAR Telephone # Verified By Clerk
Auth # No. Days

Receipt #
$
Paid By, Cash Check Credit Card
Auth. #
Initials Date
Remarks 7/11/89 called PHR put in hold indefinitely (El

Deposit Calculation CK BAD DEBTS
Est Days Est Cost
R&B FINANCIAL ARR - Discussed With
MISC
DEDUCTIBLE
TOTAL EST PAYMENT PLAN ( ) Y ( ) N
COLLECT ON ADM DUE ON D/C
Qualifies for Courtesy Discharge ( ) Y ( ) N Notification Sent

CREDIT COPY EXHIBIT A



ROPER HOSPITAL, INC.
318 Calhoun St.
Charleston, S.C. 29401-1125

57-0828733
57-0828733
42-0007
400872
101

PATIENT'S LAST NAME / FIRST NAME: MITH, FRED L
6028 OVERHILL ST
RAVANEL SC29470

| BIRTH DATE | SEX | MS | ADMISSION DATE | HR | TYPE | SRC | | | STAT | STATEMENT COVERS PERIOD FROM | THROUGH | COV D | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 8/13/36 | M | D | 07/10/89 | 20 | 1 | 7 | | 15 | 01 | 07/10/89 | 08/09/89 | 30 | | | | 470 |

| | OCCURRENCE DATE | CD | DATE |
|---|---|---|---|
| 2 | 08/09/89 | 11 | 07/10/89 |

FRED F SMITH
6028 OVERHILL ST

RAVANEL SC29470

CONDITION CODES: 80

| VALUE CD | AMT |
|---|---|
| 01 | 189.00 |

| DESCRIPTION | | REV. CODE | UNITS | TOTAL CHARGES | NON-COV |
|---|---|---|---|---|---|
| NTERMEDIATE CARE | 241.00 | 200 | 30 | 7230.00 | |
| HARMACY | | 250 | 404 | 6340.10 | |
| V SOLUTIONS | | 258 | 278 | 4469.00 | |
| ED-SURG SUPPLIES | | 270 | 431 | 4496.00 | |
| LINICAL LABORATORY | | 300 | 308 | 11299.00 | |
| ATHOLGY LAB | | 310 | 4 | 148.00 | |
| X X-RAY | | 320 | 8 | 395.00 | |
| T SCAN | | 350 | 1 | 410.00 | |
| R SERVICES | | 360 | 13 | 980.00 | |
| NESTHESIA | | 370 | 14 | 270.00 | |
| LTRASOUND | | 402 | 1 | 129.00 | |
| ESPIRATORY SVC | | 410 | 4 | 154.00 | |
| MERGENCY ROOM | | 450 | 1 | 148.00 | |
| ECOVERY ROOM | | 710 | 2 | 225.00 | |
| KG/ECG | | 730 | 2 | 60.00 | |
| ELEMETRY | | 732 | 5 | 600.00 | |
| T CONVENIENCE/OTHER | | 999 | 1 | 4.00 | 4.00 |
| TOTAL CHARGES | | 001 | | 37357.10 | |

| PAYER | REL INFO | ASG BEN | DEDUCTIBLE | CO-INSURANCE | EST RESPONSIBILITY | PRIOR PAYMENTS | EST AMOUNT DUE |
|---|---|---|---|---|---|---|---|
| .12 TRAVELERS | Y | Y | | | 37357.10 | | |

DUE FROM PATIENT ▶

| INSURED'S NAME | SEX | REL | CERT.-SSN-HIC-ID NO. | GROUP NAME | INSURANCE GROUP NO. |
|---|---|---|---|---|---|
| RED SMITH | M | 01 | 249567050 | TRAVELERS | CAP STAFFING |

| EMP | ESC | EMPLOYER NAME | EMPLOYEE ID | EMPLOYER LOCATION |
|---|---|---|---|---|
| | 1 | CAP STAFFING | 249567050 | |

PRIN. CODE: 789.0

| PRINCIPAL PROCEDURE CD | DATE | OTHER PROCEDURE CD | DATE | OTHER PROCEDURE CD | DATE |
|---|---|---|---|---|---|
| 54.11 | 7-10 | 45.62 | 7-10 | 53.49 | 7-10 |

ATTENDING PHYSICIAN ID: 248-78-8006 WIETERS, T
OTHER PHYSICIAN ID: 248-78-8006

REMARKS: Payment agreement

EXHIBIT B

FC 57-1

PAYER COPY

PROVIDER REPRESENTATIVE X
DATE 8-18-89

Senate Permanent Subcommittee
on Investigations

EXHIBIT # 8

UNITED STATES SENATE

PERMANENT SUBCOMMITTEE ON INVESTIGATIONS

STATEMENT FOR THE RECORD BY GERALD GRIMES, COMMISSIONER

OKLAHOMA STATE INSURANCE DEPARTMENT

TUESDAY, MAY 15, 1990

**GERALD GRIMES, Commissioner**

STATE INSURANCE DEPARTMENT

May 4, 1990

Mark Webster
U.S. Senate Permanent Subcommittee
on Investigations
Russell Building, Room 100
Washington, DC 20510

Re: Statement for hearing record

Dear Mark:

Please find enclosed the statements Commissioner Grimes wanted read into the record at the upcoming hearings.

I hope all goes well. If the Oklahoma Department can be of further assistance, please call. Copies of this statement have been sent to all members of the Oklahoma congressional delegation.

Sincerely,

GERALD GRIMES
Insurance Commissioner

Lynn Rambo-Jones

LYNN RAMBO-JONES
Assistant General Counsel
P.O. Box 53408
Oklahoma City, Oklahoma 73152-3408
(405) 521-2746

LRJ:bas

STATE OF OKLAHOMA • 1901 N. WALNUT • P.O. BOX 53408 • OKLAHOMA CITY, OK. 73152-3408

# GERALD GRIMES
# INSURANCE COMMISSIONER
# STATE OF OKLAHOMA
# STATEMENT TO THE SENATE SUBCOMMITTEE
# METS AND MEWAS

In Oklahoma the problems with METS and MEWAS are constant and pervasive. The fact that these entities hide behind federal preemption and claim exemption from State regulation results in many difficulties, particularly the discovery of their very existence.

Often the operation of a trust is discovered only when the marketing process is well underway and people are already enrolled or more commonly when the trust can no longer pay its claims. In most cases the trust is headquartered in another state making access to information even more limited and cost prohibitive.

As Insurance Commissioner I am forced to request information from the very entity I suspect of an illegal activity. In some instances the principals drain as much money from a trust as possible, and when regulators get close to shutting down the operation, the organizers vanish--only to reqroup as a new trust.

My attempts to involve the Department of Labor by requesting opinion letters and information has been as frustrating as it is futile. The amount of time that elapses before a Department of Labor response is obtained usually makes the information useless when received.

These entities pose a threat to the public because of their misleading similarity to licensed insurance companies. They typically market through agents, provide certificates and policies like insurers and use nomenclature generally associated with insurance products.

The similarities, however, stop there. Unlike licensed insurance companies these abusive trusts do not pay premium taxes, meet minimum benefits standards, nor protect their plan members by Guaranty Association membership.

How then do they manage to expand so rapidly? The answer is simple--they sell their products at artificially low prices operating on a cash flow basis rather than follow actuarially sound principles and establish reserves for future claims. Simply stated the managers of these abusive trusts first line their pockets through inflated administrative fees and then pay claims with the money coming in the door through sales. Our experience has shown that if the cash flow is interrupted the scheme collapses leaving the plan members without coverage, unpaid medical bills and often times uninsurable. In other words they are sometimes left in far worse straits then if they had purchased nothing at all.

When they turn to the State Insurance Department for help, there is very little that can be done. No leverage exists because no money is on deposit with the state. Citizens have a difficult time understanding the regulator's lack of control. It is very frustrating for the public and regulators alike.

The solution is clear. If the federal government continues to allow the existence of METS and MEWAS it must properly regulate them. The lack of guidelines and the many gray areas have promoted an enormous business which preys on people who are attempting to provide their families and themselves with protection against the catastrophic costs of health care. The simple regulatory solution is to require the Department of Labor to mandate prior approval and the issuance of a license before any entity can claim ERISA status. If a license was required of METS & MEWAS before the commencement of commercial activity, scoundrels and disreputable operators could more readily be identified, reasonable levels of financing could be required and, attempts to shut down illegal trusts would be more effective.

In closing, I am also attaching a list of trusts which have in the past operated in Oklahoma. Attempts have been made to quantify this problem by estimating the amount of unpaid claims. Also attached is a list of known trusts currently operating in our State.

I. Below is a list of trusts which have in the past operated in Oklahoma, as well as an estimate of the amount of unpaid claims:

| Approximate Date of Plan's Creation | Name of Plan | Amount of Unpaid Claims Incurred |
|---|---|---|
| 1977 | Ministers Benefit Trust (allegedly began by Jim Browning in Texas. After Jim and his wife were divorced, each started his own plan. Jim's trust was called Mark II Trust) | $ 750,000 |
| 1979 | Mark II Trust | $20,000,000 (includes claims for TX & OK) |
| 1979 | Gibson Trust | $ 750,000 |
| 1982 | American Indian Trust | $ 250,000 |
| 1982 | Chiropractic Association of Oklahoma Health Trust Plan | $ 42,000 |
| 1982 | American Indemnity Trust | $ 250,000 |
| 1982 | Fringe Benefit Trust | $ 1,000,000 |
| 1984 | United Health Care Benefit Trust | $ 50,000 |
| 1985 | South Central Health Trust | $ 750,000 |

II. In addition to the above listed self-insured trusts, Oklahoma has also experienced problems with trusts which are affiliated with licensed insurance carriers. Below are two examples:

A. Double Eagle Trust - this trust was initially fully insured. It was first underwritten by Hermitage Insurance Company, a Tennessee carrier. The trust literally broke Hermitage and after Hermitage was declared insolvent, approximately $30,000 in claims were paid by the Oklahoma Guaranty Fund. The trust then "rolled-over" to Continental Bankers of the South, another Tennessee insurance company. Again, the trust broke the Company and approximately $1.2 Million in claims were paid by the Oklahoma Guaranty Fund. Once again the trust "rolled" its business, this time to Keystone Insurance Company, a Texas carrier. Keystone eventually was declared insolvent as a result. The amount of claims incurred by Keystone is unknown.

B. American Legion Employee Benefit Plan - Underwritten by Lumberman's Life Insurance Company. Resulted in Lumberman's insolvency and approximately $746,000 in claims.

III. Finally, below is a list of trusts which are currently operating in Oklahoma. Many of these plans purport to be ERISA. It is unknown as to whether these plans are solvent and whether there are additional plans currently operating in our State.

C.A.R.E.
C.R.E.A.T.E. (The Council for Recreation, Energy, and Tourist Enrichment)
Diversified Industrial Group
G.R.I.P.
M.T.O. (Medical Trust of Oklahoma)
S.B.A. (Supplemental Benefits Association)
United Health Care Benefit Trust

Senate Permanent Subcommittee
on Investigations

EXHIBIT # 9

## UNITED STATES SENATE
## PERMANENT SUBCOMMITTEE ON INVESTIGATIONS
### STATEMENT FOR THE RECORD BY DR. FRANK P. STOUT
### PRESIDENT, STOUT PROPERTIES
### TUESDAY, MAY 15, 1990

S·T·O·U·T
PROPERTIES

May 7, 1990

Statement of Dr. Frank P. Stout
Submitted for the record before the U.S. Senate
Permanent Subcommittee on Investigations
May 15, 1990.

Mr. Chairman and Members of the Subcommittee, My name is Frank P. Stout, President of Stout Properties, Inc. (formerly Heart of Fayetteville Motel, Inc.). I am pleased to assist the Subcommittee in its investigation into multi-employer welfare arrangements and abuses in some of those programs. My company is a victim of one of those plans.

In my various business ventures, I employ approximately 200-300 people in North Carolina in a given year. We originally offered Aetna as health insurance coverage, but in the late part of 1988 we were approached by David Bias, a health insurance agent, about a plan called Cap Staffing. We started insurance coverage with Cap Staffing December 15, 1988.

During the period of coverage, my company and employees paid premiums in good faith to Cap Staffing. We were not aware of the pending problems of Cap Staffing until my employees starting notifying us that claims were not being paid. We were informed neither from Cap Staffing nor Mr. Bias that Cap Staffing was having financial problems. Consequently, my company continued payment for this coverage.

After an internal investigation, I became aware that Cap Staffing was bankrupt and was advised again by Mr. Bias to continue coverage with another insurance company called Universal Staffing. By now, I had become very concerned with Mr. Bias' recommendations, but because of special circumstances it was necessary to continue coverage with Universal Staffing until my employees could be moved to Blue Cross/Blue Shield our present insurance company.

Eutaw Village Shopping Center • PO Box 35068 • Fayetteville, NC 28303 • (919) 484-2662 • FAX (919) 483-2912

To date my employees have several outstanding claims with Cap Staffing and Universal Staffing. Mrs. Sheila Malie an employee with my firm for several years developed cancer. She was placed in the hospital to remove the cancerous growth and then released to begin a long period of chemotherapy. During this period, Cap Staffing was placed into bankruptcy and Universal Staffing stopped paying their claims. Mrs. Malie, whose cancer was arrested at one point has developed cancer again. She presently has medical claims of approximately $ 9,000. that are outstanding. Other Stout Properties employees have claims outstanding and some unable to pay are being turned over to the collection bureau for lack of payments. Several employees have made special arrangements to pay, but the hardship and embarrassment resulting from the negligence of Cap Staffing and Universal Staffing is profound.

I have contacted the Department of Labor in Washington, D.C., the North Carolina Insurance Commissioner's Office, the Travelers Ins. Co. in Hartford, Connecticut, and Charlotte, N.C., both Cap Staffing and Universal Staffing, all to no avail. I contacted a local attorney. He advised me that no class action suit could be brought against Travelers Insurance Company at this time.

Stout Property employees presently have outstanding unpaid claims in the amount of $20,000. approximately. We welcome and join Senator Sam Nunn's subcommittee's efforts to bring these fraudulent insurance companies and individuals to justice and hope that some assistance due so many innocent victims can be realized.

Sincerely,

Frank P. Stout, D.D.S., M.S.D., P.A.

FPS/lo

Senate Permanent Subcommittee
on Investigations

EXHIBIT # 10

UNITED STATES SENATE

PERMANENT SUBCOMMITTEE ON INVESTIGATIONS

STATEMENT FOR THE RECORD BY

THE COALITION OF ASSOCIATION EMPLOYEE BENEFIT PLANS

TUESDAY, MAY 15, 1990

The Coalition of Association
Employee Benefit Plans
1120 Vermont Avenue, NW
Suite 1000
Washington, DC 20005

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# Preserving Health Care Coverage for Small Employers Through Association-Sponsored Health Plans

## Background

The Coalition of Association Employee Benefit Plans (the "Coalition") represents associations that sponsor health plans for their members. There are thousands of such plans serving small employers in every state. For example, the Michigan Automobile Dealers Association ("MADA") has sponsored a health plan for a number of years, providing coverage to thousands of individuals.

Trade associations exist for the purpose of providing solutions to businesses with common problems. As the availability of medical coverage has become a significant issue for many employers, trade associations have responded by providing vehicles for obtaining such coverage. The basic concept is to aggregate the employer members of the association to spread the risk of claims in an efficient and cost-effective health plan. The plan can then either solicit bids from an insurance carrier seeking more advantageous large group rates, or it can self-insure the group. In other words, the association can offer small businesses the same health coverage terms as large employers or collectively-bargained plans can obtain.

Associations in various trades have joined together to establish the Coalition because of a number of regulatory constraints that are making it more difficult for us to serve our members. We are concerned that, without any action to address our problems, the association-sponsored plan option will no longer be available to thousands of small employers. Given the reluctance of most health insurers to contract with small employers, the demise of the association-sponsored plan would exacerbate the current difficulties in providing affordable health care coverage to small business.

## Major Issues

### 1. Preserving the Association Plan Option

Despite an impressive record in providing health care coverage, association-sponsored plans have more recently come under attack from state and federal regulators. The culprit has been so-called "Multiple Employer Trusts" or "MET's," which masquerade as association-sponsored plans.

No one is more concerned about MET's than our members. These false association plans prey on our members by offering illusory coverage at rates that guarantee insolvency at some point. The MET operator, of course, does not care about serving his subscribers; unlike our plans, employers subscribing to MET's are not members of an association in any real sense of the word.

The problem is that the regulators do not distinguish between true association plans and MET's. In far too many instances, regulators have acted against true association plans and allowed MET's to run free until the situation becomes too obvious to hide. This is a central irony in the current situation: because a true association operates legitimately and has roots in the community, its activities are open for everyone to scrutinize. By contrast, the MET conceals its activities until it is too late and the operator has fled to another jurisdiction.

The Coalition advocates strict licensure and registration provisions that would distinguish between true association plans and MET's. The Congress intended that result in 1982 when it provided an exemption procedure in ERISA for true association plans. Specifically, ERISA § 514(b)(6) provides that true association plans should be treated like other employee benefit plans for purposes of state insurance law, while MET's should be considered unlicensed insurance companies. The Department of Labor ("DOL") was charged with the responsibility of administering this exemption procedure, but DOL has refused to follow Congress' direction and undertake the important job of distinguishing between association plans and MET's. We would hope that members of Congress who are concerned about providing coverage for small business would encourage DOL to work with us to fashion a tough registration procedure for association- sponsored plans.

## 2. Improving the Legal Climate for Association Plans

The regulatory problems caused by MET's are not the only ones faced by association plans. Unlike collectively-bargained multiple employer plans and the programs of large employers, our plans are subject to numerous state and federal requirements designed for insurance companies and not employee benefit plans. For example, state mandated benefit laws prevent us from tailoring our plans for our members, and worse, drive up the cost of coverage beyond our members' ability to pay. Similarly, federal tax law discourages us from establishing trusts that are conservatively funded so that we can back up the promises we make to our members.

We intend to develop an agenda of specific changes that would address the problems currently inhibiting our ability to serve our members. We hope to work with the Congress, state regulations, DOL and IRS to solve these problems.

## Conclusion

The Coalition wants to build upon the excellent record of association-sponsored plans. We truly believe that our plans must be an integral part of any strategy to assure that small business has access to affordable health care coverage.

Senate Permanent Subcommittee
on Investigations

EXHIBIT # 11

# WRITTEN TESTIMONY OF DONALD V. HOLLAND
ASSISTANT DIRECTOR
OF THE ADMINISTRATIVE LAW SECTION
OF THE GEORGIA INSURANCE DEPARTMENT
BEFORE THE
U.S. SENATE PERMANENT SUBCOMMITTEE ON INVESTIGATIONS

HEARINGS ON
FRAUD AND ABUSE IN EMPLOYER SPONSORED
HEALTH BENEFIT PLANS
MAY 15, 1990

Mr. Chairman, I welcome the opportunity to present written testimony on the very serious problem encountered at the state level because of self funded Multiple Employer Welfare Arrangements ("MEWA") operating under the Employee Retirement Income Security Act of 1974 ("ERISA").

In 1988, an investigation of a consumer complaint disclosed that an organization named OMNI Health Benefit Plan ("OMNI") was selling major medical coverage to Georgia employers through its administrator, Habor Medical Administrators of Georgia ("Harbor"). The persons operating OMNI claimed to be an ERISA welfare benefit plan.

OMNI's major medical insurance product was being sold through independent insurance agents not only in Georgia, but in Alabama, Virginia, North Carolina, South Carolina and Tennessee. OMNI's assets consisted entirely of employer/employee contributions partly in cash, but mainly as an account receivable. In other words, claims could not be paid until the employer/employee contributions were paid. All MEWA's we have subsequently investigated are operating on the same cash flow basis. The employer/employee contributions were used not only to pay claims, but administrative costs, including but not limited to , personal credit card charges for OMNI principles and automobile payments for a union official in Tennessee. At the time the Georgia Insurance Department "shut down" OMNI, its assets totaled $175,965.32 with outstanding claims in excess of $690,000.00. Harbor had collected premiums in excess of $2 million from its inception in November, 1987 until August, 1988.

Since OMNI, we have discovered ten other MEWA's operating in Georgia. Three are located within Georgia while the remainder are located outside Georgia. Since financial reports are not filed with the Georgia Insurance Department, we desperately need federal assistance in this area. We rely on information contained in Form 5500's filed with the Federal Internal Revenue Service ("IRS") and the U.S. Department of Labor.

Unfortunately, three of the four Form 5500's we have reviewed on separate MEWA's were not completed or filed with an independent public accountant's opinion as required for MEWA's with 100 or more members.

Information we have obtained on nine MEWA's which operate in Georgia shows a total of approximately 17,055 participants. These figures represent totals for participants located in Georgia.

While Georgia residents insured under policies issued by licensed insurers are protected by various state laws which provide a safety net for various contingencies, no such law covers MEWA participants.

What is most distressing is that employees seeking insurance through a MEWA do not realize they are in a self funded program. I have not spoken to a single employer who realized that he or she had entered into a self funded program with its resulting liability. What is worse, most insurance agents have no idea that they are selling a self funded program.

Today, fraud is being perpetrated against the employees of those employers, who usually employ fifty employees or less. Persons who are in fiduciary positions are enriching themselves to the detriment of the beneficiaries of the MEWA Trust. This includes not only exorbitant administrative fees, but personal enrichment from commissions paid on group life as well as excess loss policies of insurance. Unless criminal sanctions are imposed where appropriate, these indiscretions will continue. At this time we are working closely with the Inspector General's Office in providing what evidence we have to, hopefully, bring about criminal prosecutions, when appropriate.

Recommendations:

1. The Department of Labor currently provides advisory opinions on plans that claim to be MEWA's, at the request of State insurance departments. However, these advisory opinions typically address only the issue of state jurisdiction. The Department of Labor should also be required to address the issue of whether or not these plans meet the requirements of a MEWA pursuant to ERISA. i.e. Is the MEWA established or maintained by an employer or employee organization, or by both, to provide benefits to employees of two or more employers? This would assist the state in ascertaining whether such plan is a MEWA authorized under ERISA, and subject to State jurisdiction by virtue of 29 U.S.C. § 1144(b), or an unauthorized insurer. Attached please find our office's correspondence with DoL dealing with this issue.

2. Standards must be set in 29 U.S.C. §§ 1002 and 1144 to insure that self funded multiple employer welfare arrangements (MEWAS) are established and maintained by bona fide employer or employee organizations. Such organizations must have legitimate purposes other than the sponsoring of an employee benefit plan. In order to avoid the formation of fraudulent organizations, these plans should be reviewed and approved by an appropriate regulatory agency prior to operation.

Current federal law allows MEWAs to be established or maintained by employers or employee organizations. In order to obtain more control over self funded MEWAS, the term MEWA, as defined in 29 U.S.C. § 1002(40)(A), should be changed to "an employee welfare benefit plan, or any arrangement which is both established and maintained for the purposes described in paragraph (1) to the employees of two or more employers..." This would also assist in avoiding the formation of fraudulent groups. (Note: 29 U.S.C. § 1002(1) would also have to be amended to provide for this exception as to self funded MEWAs.)

3. Amend 29 U.S.C. § 1144 to prohibit self funded MEWAs from being marketed through insurance agents as a substitute for commercial insurance. By cutting off the marketing arm of plans that are not properly formed under 29 U.S.C. §§ 1002 and 1144, the spreading of fraudulent plans would be greatly reduced.

4. The IRS and DoL need to have procedures for the prompt and adequate review and evaluation of form 5500 and related documents.

November 1, 1989

Mr. John Keene
Employee Benefit Plans Specialist
United States Department of Labor
Pension and Welfare Benefits Administration
Room N-5646
200 Constitution Avenue, NW
Washington, DC 20210

RE: Request for Department of Labor Opinion - National Business Association Trust

Dear Mr. Keene:

On October 24, 1989, the Honorable Warren D. Evans, Commissioner of Insurance of the State of Georgia, issued a Cease and Desist Order against National Business Association Trust ("NBAT"). NBAT represents that it is an employee welfare multiple employer welfare arrangement operating pursuant to the Employee Retirement Income Security Act of 1974, as amended, 29 U.S.C. § 1001 et seq. ("ERISA"). NBAT is administered by National Benefit Administrators, Incorporated, and local marketing in Georgia is done by Group Concepts.

I hereby request a Department of Labor opinion as to whether or not NBAT is an employee welfare benefit plan under ERISA, and whether or not it is a multiple employer welfare arrangement under ERISA. I am enclosing copies of the following documents:

1. Cease and Desist Orders
2. Trust Agreements
3. Plan Document and Summary Plan Description
4. Schedule of Benefits
5. List of Georgia groups (as furnished by Group Concepts)

If you need any additional information or documentation in this matter, please do not hesitate to call me at (404) 656-2060. We anticipate that NBAT will request an administrative hearing in this matter, and may file for a declaratory judgment in federal court. Therefore, we request that you expedite your response. Thank you for your assistance.

Sincerely,

L. J. Darter, III
Enforcement Officer

LJD:aa

STOP THE PRESSES! I HAVE A BIG SCOOP!
Up, Up and Away, to me!

U.S. DEPARTMENT OF LABOR
200 CONSTITUTION AVE, N.W.
WASHINGTON, D.C. 20210

COMMUNICATION CENTER

DATE: 12-12-89

THIS COVER SHEET IS FOR THE TRANSMITTAL OF FAX'S MESSAGES ONLY

OUR FAX FTS NBR IS 52307312 OR 523-6264
COMMERICAL NBR (202) 523-7312 OR 523-6254
VERIFICATION NBR FTS 523-6194
COMMIRICIAL NBR (202) 523-6194

FAX PHONE NBR: 404-656-7628 LOCATION: Atlanta, GA

TO: L. J. Martin III

FM: RWBaforeI/DOC, Rm. N-5671 LOCATION N-5671

THIS FAX TRANSMITTAL CONSISTS OF 3 PAGE(S) (EXCLUDING COVER SHEET

IT FOR ANY REASON YOU DO NOT RECEIVE ALL OF THE PAGE(S) PLS CALL
523-6194

**U.S. Department of Labor** Pension and Welfare Benefits Administration
Washington, D.C. 20210

89-33A

Mr. L. J. Darter, III
Georgia Insurance Commission
Seventh Floor, West Tower
Floyd Building
2 Martin Luther King, Jr., Drive
Atlanta, Georgia 30334

Dear Mr. Darter:

This is in reply to your request for an advisory opinion regarding the applicability of title I of the Employee Retirement Income Security Act of 1974 (ERISA). Specifically, you ask whether the National Business Association Trust (NBAT) is an employee welfare benefit plan within the meaning of section 3(1) of title I of ERISA and whether NBAT is a multiple employer welfare arrangement (MEWA) within the meaning of section 3(40) of that title.

You advise that NBAT was created pursuant to a trust agreement dated July 24, 1987, between the Coca-Cola Bottling Co. of S.E. Missouri and other unnamed corporations as the Company and Charles Sander as Trustee. The trust agreement states that it is an amendment of and successor to the Mid America Soft Drink Bottling Trust. The trust agreement states that the Company intends to adopt health care and welfare plans for the benefit of its employees and that it provides for the creation of a MEWA within the meaning of section 3(40) of title I of ERISA. The term "Company" is defined to include all employers which thereafter participate in NBAT. There are approximately 68 employers utilizing NBAT to provide medical coverage to their employees. In a telephone conversation with John Keene of this Office, you also stated that the employers utilizing NBAT to provide benefits to their employees do not constitute a controlled group and that NBAT is not maintained pursuant to any collectively bargained agreement.

Section 3(40)(A) of title I of ERISA defines the term "MEWA" to include:

> . . .an employee welfare benefit plan, or any other arrangement (other than an employee welfare benefit plan), which is established or maintained for the purpose of offering or providing any benefit described in paragraph (1) to the employees of two or more employers (including one or more self-employed individuals), or to their beneficiaries, except that such term does not include any such plan or other arrangement which is established or maintained--

> (i) under or pursuant to one or more agreements which the Secretary finds to be collective bargaining agreements, or
>
> (ii) by a rural electric cooperative.

Based upon the information you submitted, it is the position of the Department of Labor (the Department) that NBAT is a MEWA within the meaning of section 3(40). NBAT covers the employees of more than two separate, independent employers; is not maintained by a rural electric cooperative; and is not maintained under or pursuant to any collective bargaining agreement.

Although section 514(a) of ERISA provides that any state law or regulation which relates to an employee benefit plan covered by ERISA is preempted, P.L. 97-473 amended section 514(b) of title I of ERISA to provide:

> (6)(A) Notwithstanding any other provision of this section-- (i) in the case of an employee welfare benefit plan which is a multiple employer welfare arrangement and is fully insured (or which is a multiple employer welfare arrangement subject to an exemption under subparagraph (B)), any law of any State which regulates insurance may apply to such arrangement to the extent that such law provides--
>
> (I) standards, requiring the maintenance of specified levels of reserves and specified levels of contributions, which any such plan, or any trust established under such a plan, must meet in order to be considered under such law able to pay benefits in full when due, and
>
> (II) provisions to enforce such standards, and
>
> (ii) in the case of any other employee welfare benefit plan which is a multiple employer welfare arrangement, in addition to this title, any law of any State which regulates insurance may apply to the extent not inconsistent with the preceding sections of this title.
>
> (B) The Secretary may, under regulations which may be prescribed by the Secretary, exempt from subparagraph (A)(ii), individually or by class, multiple employer welfare arrangements which are not fully insured. Any such exemption may be granted with respect to any arrangement or class of arrangements only if such arrangement or each arrangement which is a member of such class meets the requirements of section 3(1) and section 4 necessary to be considered an employee welfare benefit plan to which this title applies.

Although section 514(b)(6)(B) provides that the Secretary of Labor may prescribe regulations under which the Department may exempt MEWAs from state regulation under section 514(b)(6)(A)(ii), the Department has previously stated that it did not see the need

to prescribe regulations under section 514(b)(6)(B) to exempt MEWAs from state regulation. The Department, at this time, has not changed its position. Accordingly, the Department is not providing MEWAs exemptions under section 514(b)(6)(B) from state regulation.

It is, therefore, the Department's position that NBAT is subject to state regulation at least to the extent provided in section 514(b)(6)(A), regardless of whether it is an employee benefit plan covered by title I of ERISA, because it is a MEWA within the meaning of section 3(40) of that title.

Because your request for an advisory opinion was concerned primarily with the issue of whether or not NBAT is subject to the applicable regulatory authority of the State of Georgia's insurance laws or is saved from such authority under the general preemption provision of section 514(a) of title I of ERISA, and because of the opinion above, we have determined it is not necessary at this time to render an opinion as to whether NBAT is an employee welfare benefit plan within the meaning of section 3(1) of that title.

The preceding constitutes an advisory opinion under ERISA Procedure 76-1. Accordingly, it is issued subject to the provisions of that procedure, including section 10 thereof relating to the effect of advisory opinions.

Sincerely,

Robert J. Doyle
Director of Regulations and Interpretations

OFFICE OF
COMMISSIONER OF INSURANCE

WARREN D. EVANS
COMMISSIONER OF INSURANCE
SAFETY FIRE COMMISSIONER
INDUSTRIAL LOAN COMMISSIONER
COMPTROLLER GENERAL

SEVENTH FLOOR, WEST TOWER
FLOYD BUILDING
2 MARTIN LUTHER KING, JR. DRIVE
ATLANTA, GEORGIA 30334

March 4, 1990

Mr. Robert J. Doyle
United States Department of Labor
Pension and Welfare Benefits Administration
200 Constitution Avenue, N.W.
Room N-5671
Washington, D.C. 20210

Dear Mr. Doyle:

This is in reference to your advisory opinion number 89-33A, dated December 12, 1989, concerning National Business Association Trust (NBAT).

In that opinion, you expressed the Department's position that NBAT is subject to state regulation at least to the extent provided in Section 514(b)(6)(A) of ERISA. You then stated that "we have determined it is not necessary at this time to render an opinion as to whether NBAT is an employee welfare benefit plan within the meaning of Section 3(1) of that title."

NBAT has since withdrawn its request for a hearing. Therefore, the Cease and Desist Order issued by the Commissioner of Insurance of the State of Georgia, as amended, remains in force.

This leaves unresolved the issues of responsibility for unpaid claims of NBAT (if any) and premium taxes. Section 33-23-20 of the Georgia Insurance Code (O.C.G.A. § 33-23-20) provides the following:

> No person within this state shall solicit, procure, receive, or forward applications for life or accident and sickness insurance or annuities nor issue or deliver policies for or in any manner secure, help, or aid in the placing of any contract of life or accident and sickness insurance or annuity for any person other than himself, directly or indirectly, with an insurer not authorized to do business in this state. The person shall be liable for the full amount of any

> loss sustained on any contract of life or accident and sickness insurance or annuity made by or through him or it, directly or indirectly, with any insurer not authorized to do business in this state and, in addition, shall be liable for any premium taxes which may become due under any law of this state by reason of the contract.

Thus, the issue is whether NBAT is "an insurer not authorized to do business in this state." If so, the agents who sold it are liable for any losses sustained (unpaid claims) and for premium taxes. Therefore, at this time we need your opinion as to whether NBAT is an employee welfare benefit plan within the meaning of Section 3 (1) of ERISA. If it is such a plan, is it exempted under ERISA from the requirement that it have a certificate of authority to transact insurance in Georgia? In other words, is NBAT authorized to do business in Georgia without a certificate of authority by virtue of its status under ERISA?

Thank you for your assistance in this matter.

Sincerely,

L. J. Darter, III
Enforcement Officer

LJD:aa

U.S. Department of Labor

Pension and Welfare Benefits Administration
Washington, D.C. 20210

RECEIVED
APR 19 1990
ADM

APR 11 1990

Mr. L. J. Darter, III
Georgia Insurance Commission
Seventh Floor, West Tower
Floyd Building
2 Martin Luther King, Jr., Drive
Atlanta, Georgia 30334

Dear Mr. Darter:

This responds to your letter of March 4, 1990, regarding the National Business Association Trust ("NBAT").

Your letter follows upon Opinion 89-33A (issued to you December 12, 1989) in which the Department of Labor ("the Department") concluded that NBAT was a "multiple employer welfare arrangement" ("MEWA") within the meaning of section 3(40) of title I of the Employee Retirement Income Security Act of 1974 ("ERISA"). Specifically, you raise the matter that, as stated in the opinion letter, the Department determined it was not necessary at that time to render an opinion as to whether NBAT was an "employee welfare benefit plan" within the meaning of section 3(1) of title I of ERISA. You explain that a cease and desist order issued by the Commissioner of Insurance of the State of Georgia ("the Commissioner") has been in force against NBAT and that the Commissioner's Office currently is seeking to determine responsibility under the Georgia Insurance Code for any unpaid claims of NBAT and premium taxes. You indicate that such responsibility depends on whether NBAT was subject to the state law requirement to have a certificate of authority to transact insurance in Georgia. You believe that question may require an opinion by the Department as to whether NBAT was an employee welfare benefit plan within the meaning of section 3(1) of ERISA. We disagree as explained below.

Section 514(b)(6) of ERISA provides an exception to preemption under ERISA section 514(a) for any employee welfare benefit plan (as defined by section 3(1) of ERISA) that is a MEWA. In general, the exception permits application of state insurance law to a MEWA as follows: If the MEWA is "fully insured" within the meaning of section 514(b)(6)(D) of ERISA, state insurance law may apply to the extent it provides standards requiring the maintenance of specified levels of reserves and contributions, and provisions to enforce such standards. If the MEWA is not fully insured, state insurance law may apply to the extent not inconsistent with title I of ERISA. Thus, for example, state laws requiring a certificate of authority to transact insurance generally would not be preempted with respect to an ERISA-covered employee welfare benefit plan that is a MEWA and is not fully insured.

We note that the Commissioner has taken the position that NBAT was not fully insured within the meaning of ERISA section 514(b)(6)(D). (See item 12 under "Findings of Fact" in the Cease and Desist Order dated October 24, 1989.) It follows from that position that, even if NBAT were an employee welfare benefit plan within the meaning of ERISA section 3(1), application of Georgia insurance law to NBAT generally has not been preempted under section 514 of ERISA. Therefore, it appears unnecessary to obtain an opinion from the Department on the status of NBAT under section 3(1) of ERISA in order for the Commissioner to determine whether the Georgia certificate of authority requirement applied to NBAT.

I hope you find this information to be helpful.

Sincerely,

Helene A. Benson

Helene A. Benson
Chief
Division of Coverage
Office of Regulations
and Interpretations

Senate Permanent Subcommittee
on Investigations
EXHIBIT # 12

UNITED STATES SENATE

PERMANENT SUBCOMMITTEE ON INVESTIGATIONS

STATEMENT FOR THE RECORD BY JOHN W. BLEDSOE, III, P.A.

TUESDAY, MAY 15, 1990

**JOHN W. BLEDSOE, III, P.A.**
ATTORNEY AT LAW
POST OFFICE BOX 250 • 325 WEST HOME AVENUE
HARTSVILLE, SOUTH CAROLINA 29550
TELEPHONE (803) 332-2255
FAX (803) 332-2257

RECEIVED BY
SENATE PERMANENT
SUBCOMM ON INVESTIGATIONS
MAY 11 1990
MAJORITY OFFICE

May 10, 1990

Mr. David Buckley
Senate Permanent Subcommittee On Investigations
Russell Senate Building, Room 100
Washington, DC 20510

RE: James Carroll Melton - Travelers Insurance Company

Dear David:

Pursuant to our telephone conversation earlier today, I am enclosing the original Affidavit of James Carroll Melton along with copies of a bill from Duke University Hospital, a letter from Allied Medical Accounts Control and a copy of Mr. Melton's insurance card.

If you have any questions at all, please don't hestiate to contact me.

Sincerely yours,

John

JOHN W. BLEDSOE, III

JWB:jsg
Enclosures
CC: Mr. James C. Melton
3104 Sawyer Street
Conway, South Carolina 29526

STATE OF SOUTH CAROLINA )
) AFFIDAVIT
COUNTY OF DARLINGTON )

Personally appeared before me James Carroll Melton of 3104 Sawyer Street, Conway, South Carolina 29526 who, after being duly sworn deposes as follows:

I was seriously injured in an automobile accident on November 4, 1988 and as a result, I was admitted to Duke University Hospital for extensive surgery and was in the hospital for approximately three weeks. Prior to my admission at Duke University Hospital, I presented proof of insurance which was provided through the Travelers Insurance Company, by contract with Cap Staffing, Inc. A copy of my medical insurance card is attached to this Affidavit. Duke University Admitting Office called the verification number on my card and was advised that I did have medical insurance coverage. The bills for that admission and the Emergency Room treatment I received total $21,619.35. This does not include the bills for the surgeons and other doctors who treated me including physical therapy which will amount to several thousand dollars more. The hospital has now been advised that this insurance has not and will not pay my medical bills for that treatment. Those bills have now been turned over to a collection agency called Allied Medical Accounts Control. This Company has contacted me incessantly in an effort to collect these bills but I am now disabled as a result of my injuries, cannot work, and I have no income and no means by which to pay these bills.

I continue to need medical treatment and I still receive physical therapy three times a week at Carolina Rehabilitation Center through the Conway Hospital. Fortunately, I have another insurance policy which is paying for this physical therapy but it does not provide coverage for any of the past treatment at Duke University Hospital nor will it pay for any other medical treatment which I need. The chief surgeon who treated me at Duke University Hospital has advised me that I need extensive surgery in an effort to improve my disability but this will require further hospitalization and will cost several thousand dollars. Unfortunately, because I have an outstanding bill and no way to pay it or future charges, I am unable to obtain this additional needed medical treatment.

The failure of Cap Staffing and the Travelers Insurance Company to honor its insurance contract and pay my medical bills has left me owing large sums of money which I will never be able to pay; and has left me totally disabled without any hope of receiving needed medical treatment.

In addition, I am now unable to obtain any medical coverage of any kind because of my disability which constitutes a pre-existing condition and which prevents me from getting coverage.

I am attaching a Duke University Hospital bill and a letter from Allied Medical Accounts Control to this Affidavit.

James C. Melton
James Carroll Melton

SWORN TO AND SUBSCRIBED TO
BEFORE ME THIS 9th
DAY OF MAY, 1990.

Sandra G Yarborough
NOTARY PUBLIC FOR SOUTH CAROLINA

MY COMMISSION EXPIRES: 11/25/97

**Duke University Hospital**
ACCOUNTS RECEIVABLE
BOX 3095
DURHAM, NORTH CAROLINA
27710

01/19/90

HISTORY NUMBER ACCOUNT NUMBER DATE
T15915 426455 07/05/89

T15915
JAMES CARROLL MELTON
3104 SAWYER ST
CONWAY SC 29526

FOR THE ACCOUNT OF
MELTON,JAMES CARROLL

YOUR ACCOUNT REPRESENTATIVE IS
MS. WATSON 426455 IP 6

DISCHARGE DATE 07/05/89
BALANCE DUE 21,139.95
STATUS FINAL NOTICE

To insure prompt and proper handling of your payment,
please detach and return this portion with your check.

FORM A35038 (4-88)

**WE HAVE NOT RECEIVED YOUR PAST DUE PAYMENT**

We notified you when payment was due on the account (or accounts) listed above, but we have not received your payment.

***You must make settlement in full within 10 days.*** We accept most major credit cards, checks or money orders. Otherwise, the balance will be considered as delinquent, and we will make a decision on turning your account over to a collection agency, suing you for the balance, or turning the account over to an attorney. If a judgment is entered against you for this debt, your wages may be subjected to garnishment for payment of the debt under certain circumstances. You can avoid such serious action by taking this opportunity to settle this debt to the hospital. Please disregard this notice if you have already mailed the payment.

Sincerely,

ACCOUNT REPRESENTATIVE
DUKE UNIVERSITY HOSPITAL
ACCOUNTS RECEIVABLE, SUPERVISOR

ADDRESS CORRESPONDENCE TO DUKE MEDICAL CENTER,
BOX 3095, DURHAM, N.C. 27710 OR CALL

919-684-2026

a division of Associated Bureaus, Inc.

**ALLIED MEDICAL ACCOUNTS CONTROL**

Associated Bureaus Building • 260 East Wentworth Avenue • St. Paul, Minnesota 55118
Area Code (612) 450-3030 • 1-800-328-0114 Toll Free
Please send payment to: Box 64231, St. Paul, Mn 55164-0231.

** PLAN TO USE YOUR TAX REFUND TO PAY YOUR BALANCE **

KEY: 01-1538-05-0003714
04/20/90

MR JAMES CARROLL MELTON
3104 SAWYER ST
CONWAY, SC 29526

DEAR MR MELTON,

OUR RECORDS SHOW YOUR ACCOUNTS AS FOLLOWS:

| | | |
|---|---|---|
| DUKE UNIVERSITY HOSP - I/P | ORT 1 426455 | $21,139.95 |
| DUKE UNIVERSITY HOSP - ER | GSU 5 426561 | $188.00 |
| DUKE UNIVERSITY HOSP - ER | GSU 5 408823 | $291.40 |

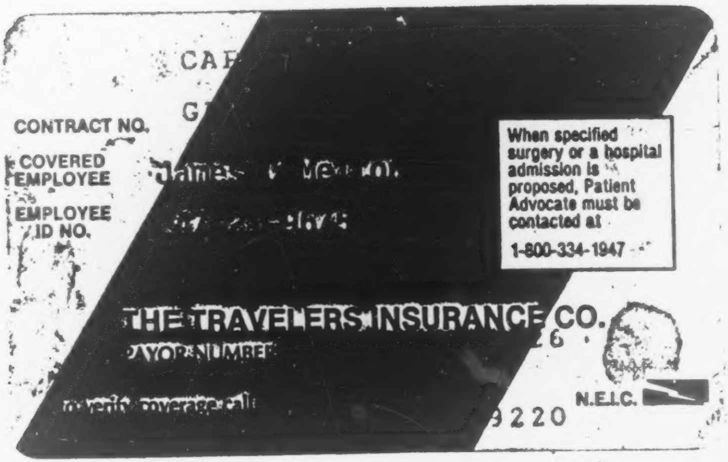
TOTAL AMOUNT DUE: $21,619.35

I HAVE TRIED TO REACH YOU WITH NO SUCCESS FOR THE PAST FEW DAYS. CALL ME AT THE PHONE NUMBER ABOVE SO WE MAY DISCUSS YOUR ACCOUNTS.

SINCERELY,

MS KIRKWOOD
COLLECTION INVESTIGATOR

Telephone calls from our representatives are recorded for our mutual protection.
This letter is written for debt collection purposes and any information obtained will be used solely for debt collection purposes.
Office hours (Central Standard Time) Mon. - Thur., 7:30 A.M. - 9:00 P.M. • Fri., 7:30 A.M. - 5:00 P.M. • Sat. ,7:00 A.M. - 12:00 P.M.



CA[illegible]

G[illegible]

CONTRACT NO.

COVERED EMPLOYEE James [illegible]

EMPLOYEE ID NO. [illegible]

When specified surgery or a hospital admission is proposed, Patient Advocate must be contacted at

1-800-334-1947

THE TRAVELERS INSURANCE CO.

PAYOR NUMBER [illegible]26

To verify coverage call [illegible]9220

N.E.I.C.

Senate Permanent Subcommittee
on Investigations

EXHIBIT # 13

UNITED STATES SENATE
PERMANENT SUBCOMMITTEE ON INVESTIGATIONS
STATEMENT FOR THE RECORD BY TRAVELERS INSURANCE COMPANY
TUESDAY, MAY 15, 1990

# FACTUAL CHRONOLOGY REGARDING CAP STAFFING, INC.'S SELF-FUNDED EMPLOYEE HEALTH BENEFIT PLAN

## GENERAL BACKGROUND

1. During the summer of 1988, Sid Raper approached a Travelers' representative in Charlotte, North Carolina, about the prospect of Travelers being the underwriter of life, accidental death and dismemberment, and health insurance coverage for an benefit plan program being established by Cap Staffing, Inc. Raper was an insurance agent or broker working with Cap Staffing. Travelers' representative and Raper met with D. Ron Harris, presumably the Vice-President of Cap Staffing, to discuss the proposal. Cap Staffing initially represented that approximately 350 "leased" employees would be covered under its employee benefit plan. The parties made no firm decision at this meeting.

2. On or about August 31, 1988, Cap Staffing held an organizational meeting at Pine Lake Country Club (believed to be located in Charlotte, North Carolina) regarding implementation of the employee leasing concept. Robert W. Long, D. Ron Harris, and Joy Coble conducted this meeting. Long was President and CEO of Cap Staffing. Harris was fraudulently introduced as a past President and CEO of Travelers. Coble operated a corporation in Charlotte, North Carolina, known as Professional Employers, Inc., which apparently was in the employee leasing business. Coble's operation was slated to be in charge of payroll and personnel administration functions for Cap Staffing. Presumably, Cap Staffing had retained the law firm of Cannon & Blair, P.A., in Charlotte, North Carolina, prior to August 31, 1988, to perform

substantial legal work in preparation for the establishment of Cap Staffing's employee leasing business.

3. During September or early October 1988, Long, Harris, and Coble held a second organizational meeting at the Ramada Inn in Charlotte, North Carolina, regarding the operation of Cap Staffing and Cap Programs.

## ESTABLISHMENT OF EMPLOYEE BENEFIT PLAN

4. During September or October 1988, a Travelers' representative in Charlotte, North Carolina, submitted a proposal to Cap Staffing for life, accidental death and dismemberment, and health insurance coverage on a fully insured basis. Cap Staffing rejected this proposal.

5. Subsequently, Long and Harris contacted Travelers' home office and arranged a meeting to discuss other possible arrangements through which Travelers could assist Cap Staffing in providing an employee benefit plan to its employees. Long and Harris then flew to Hartford, Connecticut, and met with Travelers' representatives.

6. On or about late October 1988, Travelers' home office offered Cap Staffing an "ASO (Administrative Services Only) Contract" under which Travelers would simply administer or process health claims for Cap Staffing's employee health benefit plan. Travelers did not underwrite or insure Cap Staffing's employee health benefit plan. A copy of the ASO Contract is attached as Exhibit A.

7. Cap Staffing's employee health benefit plan was to be a self-funded plan which would be funded using payroll deductions. Travelers would be reimbursed for claims processed and paid through a bank account Cap Staffing agreed to establish at Connecticut National Bank in Hartford, Connecticut.

8. On or about December 7, 1988, Cap Staffing submitted forms to Connecticut National Bank for the purported establishment of the bank account. However, Cap Staffing failed to fund the bank account as agreed in the ASO contract, except to the limited extent indicated in paragraph 20 below. Joanie Self, a bookkeeper at Cap Staffing, apparently made numerous efforts to fund the bank account but was ordered not to do so by Harris, Long, or others.

9. In connection with the ASO Contract, Travelers agreed to underwrite the life and accidental death and dismemberment aspect of Cap Staffing's employee benefit plan on a fully insured basis.

10. On November 1, 1988, the ASO Contract and the insured life and accidental death and dismemberment coverage became effective.

11. Pursuant to the ASO Contract, subject to Cap Staffing's review and concurrence, Travelers was charged with preparation of Employee Benefit Booklets. Cap Staffing delayed the timely preparation and distribution of Employee Benefit Booklets to employees by repeatedly requesting changes or seeking to add additional coverages. The Employee Benefit Booklets were

forwarded to Cap Staffing for distribution prior to or about April 1, 1989. Pages 1-13 of the Employee Benefit Booklets described the life and accidental death and dismemberment aspect of Cap Staffing's plan. Page 14 of the Employee Benefit Booklets explained that Cap Staffing's health plan was a self-funded plan, not a plan underwritten by Travelers. Pages 15-77 described the health benefits available under Cap Staffing's employee health benefit plan.

12. Pursuant to the ASO Contract, Cap Staffing agreed that if the Employee Benefit Booklets were not distributed prior to the effective date of Cap Staffing's employee benefit plan, Cap Staffing would deliver to each employee prior to the effective date of the employee benefit plan, written notification that, as of the effective date of the Plan (November 1, 1988), Cap Staffing had assumed liability for payment of the Plan benefits and that the Plan benefit payments would be administered by Travelers. Cap Staffing failed to provide written notification to the employers to which it marketed its employee leasing program (as well as their employees) explaining that Travelers' role would be to process and administer health claims and that Cap Staffing would be responsible for payment of Plan benefits.

13. Travelers believes that Cap Staffing fraudulently represented to employers and employees that Travelers was the underwriter or insurance carrier for Cap Staffing's employee health benefit plan, and that Cap Staffing intentionally failed to reveal the self-funded nature of its employee health benefit

plan so that, by misusing Travelers' goodwill and good name, Cap Staffing could deduct insurance premiums from the paychecks of employees and convert those premiums to personal or other uses of the Cap entities and the Cap principals rather than fund the bank account.

14. Pursuant to the ASO Contract, Cap Staffing also agreed to provide information and certification lists to Travelers to enable Travelers to determine eligibility as to requests for Plan benefits and to provide cost estimates and reports. Cap Staffing failed to provide accurate information and updated certification lists, despite repeated assurances that it would do so, which often resulted in Travelers' inability to identify an individual as an employee of Cap Staffing for claim benefit eligibility purposes.

15. During early spring of 1989, Travelers learned that Cap Staffing had been marketing less than full-service employee leasing contracts (e.g., payroll only or human resources contracts) even though Cap Staffing knew that employees would be eligible for participation under the ASO Contract only if full-service leasing contracts had been executed so that individuals would qualify as full-time employees of Cap Staffing. Travelers promptly informed Cap Staffing that its claim processing services under the ASO Contract were unavailable if less than full-service employee leasing contracts were executed. Travelers did so to prevent the appearance that Cap Staffing was selling Travelers' insurance, in that an individual had to be a full-time employee

of Cap Staffing to be eligible for participation under the ASO Contract. Cap Staffing assured Travelers that it would ensure that Cap Staffing representatives were marketing only full-service leasing contracts. Despite such assurances, Cap Staffing apparently continued to market less than full-service employee leasing contracts.

16. On June 2, 1989, Long purported to sell Cap Staffing and Cap Programs to a Palm City, Florida, company known as Gold Equity Management Company (GEMCO). GEMCO is operated by Michael Spieles and Michael Kre[illegible]. Spieles acting as President and Krebser acting as Vice-President. GEMCO is engaged in the mining and recovery of micro-gold in the State of Nevada.

17. Between June 2 and July 31, 1989, while GEMCO purportedly owned Cap Staffing, Spieles and Krebser apparently siphoned off in excess of $1,000,000.00 from Cap Staffing. D. G. Smith, the Controller at Cap Staffing, and Gene Armstrong, an employee or officer of Cap Programs, informed Long that GEMCO received hundreds of thousands of dollars from Cap Staffing. Jerry Wolicki, Office Manager at Cap Staffing, once instructed Armstrong to Federal Express $150,000.00 to GEMCO. Smith also sent large sums of money to GEMCO by Federal Express. Wolicki resigned in August or September 1989 and went to work for GEMCO.

18. On July 31, 1989, Long, Spieles, and Krebser signed a purported Cancellation and Rescission of Agreement in which the parties purportedly rescinded the June 2, 1989, Agreement between the parties. The July 31 Agreement recited in part that certain

"representations and disclosures made or to be made to Spieles and Krebser have either been false and misleading or have been incomplete, inaccurate or inadequate thereby making it impossible for Spieles and Krebser to accomplish the goals and objectives contemplated by the parties hereto."

19. Cap Staffing made two direct payments by checks to Travelers. One check dated December 6, 1988, and in the amount of $4,994.85, represented payment for a portion of the premium and administrative service charges due pursuant to the ASO Contract. A second check dated May 4, 1989, for $21,000.00 was returned for insufficient funds. As of May 25, 1989, Cap Staffing still had not yet funded the bank account at Connecticut National Bank, but assured Travelers that it was attempting to do so.

20. From May 26 to June 6, 1989, after Travelers had threatened to terminate the ASO Contract for breach of its terms, Cap Staffing wired Travelers approximately $215,000.00 to induce Travelers to continue administering the ASO Contract and to continue providing life and accidental death and dismemberment coverage.

21. Cap Staffing promised Travelers that by installment payments on June 15 and July 1, 1989, respectively, it would bring current all past-due premium and administrative service charges and that it would properly fund the bank account. But as of June 23, 1989, Cap Staffing had done neither. By letter dated June 23, 1989, Travelers notified Cap Staffing that the ASO

Contract would be terminated effective August 1, 1989, as a result of Cap Staffing's breach of the terms of the ASO Contract.

22. As of August 1, 1989, Travelers ceased processing claims for Cap Staffing.

23. After August 1, 1989, Travelers began logging in health claims received from purported Cap Staffing employees and forwarding such claims to Cap Staffing for payment. Travelers also began informing purported Cap Staffing employees that their health claims had been forwarded to Cap Staffing for payment.

24. Travelers discovered that it had processed and paid health claims of at least $864,000.00 by the time it terminated the ASO Contract. To date, Travelers has paid in excess of $894,000.00 in claims on behalf of Cap Staffing, for which Travelers has not been reimbursed.

25. Believing that it too had been a victim of Cap Staffing's fraudulent and outrageous conduct, on October 13, 1989, Travelers commenced an action in the United States District Court for the Western District of North Carolina, Charlotte Division, against Cap Staffing, Long, Harris and others for, inter alia, fraud, breach of contract, and unfair and deceptive trade practices. That suit is proceeding in the federal court.

THE TRAVELERS INSURANCE COMPANY

"ATTACHMENT A"

ADMINISTRATIVE SERVICES AGREEMENT

BY AND BETWEEN

CAP STAFFING, INC.

(HEREINAFTER REFERRED TO AS THE "CONTRACTHOLDER")

AND

THE TRAVELERS INSURANCE COMPANY
HARTFORD, CONNECTICUT

(HEREINAFTER REFERRED TO AS "THE TRAVELERS")

WHEREAS, the Contractholder has established an employee health benefit plan described in Exhibit A hereof (hereinafter called the "Plan") for certain of its employees and their dependents; and

WHEREAS, the Contractholder desires The Travelers to furnish the services set forth in Exhibit B hereof;

NOW THEREFORE, in consideration of the mutual promises contained in this Agreement, the Contractholder and The Travelers agree as follows:

## Section I: Responsibilities of The Travelers and the Contractholder

(a) The Contractholder retains all final authority and responsibility for the Plan and its operation. The Travelers is empowered to act on behalf of the Contractholder in connection with the Plan only as expressly stated in this Agreement or as mutually agreed to in writing by The Travelers and the Contractholder. The relationship of The Travelers to the Contractholder is that of an independent contractor and nothing in this Agreement shall be construed as creating any other relationships.

(b) The Travelers shall discharge its duties under this Agreement with the skill, care, prudence and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use. The Travelers shall not be liable for any mistake in judgment or other action taken in good faith.

(c) The Contractholder agrees to hold The Travelers and its directors, officers and employees harmless from any and all claims, lawsuits, settlements, judgments, costs, penalties, and expenses, including reasonable attorneys' fees, resulting from, or arising out of or in connection with any function of The Travelers under this Agreement, unless it is determined that the liability therefore was the direct consequence of criminal conduct or fraud on the part of The Travelers or due to the failure of The Travelers to discharge its duties in accordance with this Agreement; provided, however, that the Contractholder shall remain liable for payment of all benefits under the plan.

## Section II: Claims Administration

(a) The Travelers shall promptly process claims for plan benefits and calculate the amount due and payable and make payment or issue a denial notice. Any comments or written requests for appeals of denied claims shall be forwarded to the Contractholder for review and decision.

(b) In determining the benefits payable, if any, The Travelers shall exercise reasonable claim cost controls as described in Exhibit B.

(c) Whenever The Travelers becomes aware of an incorrect payment under the Plan, The Travelers shall make a diligent attempt to recover the amount incorrectly paid or will adjust the underpayment but The Travelers will not be required to initiate court proceeding for any such recovery.

(d) The Travelers may seek the services of experts in performing its duties under this Agreement. Should The Travelers do so without prior consultation with the Contractholder, any expense incurred shall be the responsibility of The Travelers. The Travelers shall consult with the Contractholder to legal counsel designated by the Contractholder when, in its judgment, legal to extraordinary Plan interpretation questions are involved.

(e) The Travelers shall advise the Contractholder as to matters which come to its attention involving potential legal actions which involve the Plan and shall promptly advise the Conractholder of legal actions commenced against the Contractholder which come to its attention. The defense of any legal action involving a claim for benefits under the Plan shall not be the responsibility of The Travelers under this Agreement. The Travelers shall fully cooperate with the Contractholder in the defense of any action arising out of matters related to this agreement.

## Section III: Tax Reimbursement and Payment

In the event that a state or other jurisdiction, in accordance with existing or future law, determines that The Travelers is liable for payment of taxes with respect to any aspect of the Plan, the Contractholder agrees to reimburse The Travelers for the amount of any such taxes, any interest expense assessed against or incurred by The Travelers before or after payment of such taxes, and any other charges, penalties or fines in connection therewith, including reasonable attorneys' fees, that The Travelers may sustain in connection with such taxes. Any such amount shall be due and payable upon written notification by The Travelers to the Contractholder.

The Travelers shall have sole discretion in determining whether any claim or assessment for taxes shall be paid, compromised, litigated or appealed and as to all matters of procedure, compromise, defense or appeal or any other aspects of any claim or assessment concerning its liability.

In the event that a state or other jurisdiction, in accordance with existing or future law, imposes upon The Travelers the duty to act as agent for collection of any tax imposed on the Plan or the Contractholder with respect to any aspect of the Plan, the Contractholder will pay over any such taxes to The Travelers when requested to do so by The Travelers.

The Travelers and the Contractholder each acknowledge and agree that, under the terms of this Agreement, payment of any applicable Texas administrative tax (as provided in Article 4.11 of the Insurance Code of Texas) which is based upon benefit payments or other amounts (other than fees actually paid to and received by The Travelers) is the sole responsibility of the Contractholder and that the Contractholder is responsible for collection and payment of such administrative services tax.

## Section IV: Duties of the Contractholder

In order for The Travelers to perform the benefit payment and other services for the Contractholder as set forth in Exhibit B to this Agreement, the Contractholder shall furnish to The Travelers certain information concerning the Plan and employees and dependents covered under the Plan as may from time to time be required by The Travelers as set forth in Exhibit C.

## Section V: Banking Arrangements

(a) During the term of this Agreement:

  (i) The Contractholder shall establish and maintain a bank account for the payment of benefits under the Plan in Connecticut National Bank, Hartford, Connecticut.

  (ii) All benefit payments made under the Plan will be issued by The The Travelers on drafts payable through Connecticut National Bank, Hartford, Connecticut.

(b) The Contractholder by this Agreement expressly authorizes The Travelers to issue and accept such drafts for benefit payments r the Plan on behalf of the Contractholder.

Drafts issued by The Travelers in payment of Plan fits will, after presentment by the Bank to The Travelers and if i r, be accepted by The Travelers on behalf of the Contractholder and ged to said Contractholder bank account.

(c) The Contractholder agrees that it will, in accord with arrangements agreed to between The Travelers and the Contracth

(i) provide to the bank funds for the payment of benefit payment drafts accepted by The Travelers under the Plan including withdrawal from any Special Account maintained by the Contractholder with The Travelers for the purpose of funding benefits under the Plan; and

(ii) maintain an amount as specified by The Travelers from time to time to the Contractholder on deposit with the bank equal to the total amount of drafts expected to be charged to the account during a 5 working day period.

## Section VI: Effective Date - Agreement Period

(a) This Agreement shall be effective as of November 1, 1988.

(b) The first Agreement Period shall be the period from the effective date to November 1, 1989.

(c) This Agreement shall be continued automatically, unless discontinued in accordance with Section VIII for successive Agreement Periods of twelve months each.

## Section VII: Administrative Service Charges

(a) Charges for the services set forth in Exhibit B shall be in accordance with the Schedule of Charges set forth in Exhibit D. Such charges and any applicable taxes imposed with respect to the charges shall be payable by the Trustees to the Travelers on or before the last day of each month.

(b) The Travelers shall have the right to change the Administrative Service Charge upon advance written notice to the Contractholder as of the first day of any month or as of the effective date of any amendment to the Plan or this Agreement which affects the Administrative Service Charge except that no increase in the Administrative Service Charge, other than an increase due to a Plan amendment or amendment to this Agreement shall become effective prior to November 1, 1989 or thereafter prior to Twelve months after the effective date of any previous increase in such Charge.

## Section VIII: Discontinuance of Agreement

(a) This Agreement may be discontinued at the earliest time specified below:

(i) As of the date of discontinuance of the Plan, as specified to The Travelers by the Contractholder.

(ii) As of any date agreed to between the Contractholder and The Travelers.

(iii) As of the date the Contractholder fails to provide funds to the bank as necessary for the payment of drafts accepted by The Travelers on behalf of the Contractholder for benefit payments under the Plan.

(iv) As of the last day of an Agreement Period by either party giving thirty days notice to that effect to the other party.

(b) Application of this Agreement to any state or other jurisdiction may be discontinued by The Travelers or the Contractholder as of the date either party determines that it will be penalized for such state or other jurisdiction for proceeding with its performance under this Agreement.

(c) Discontinuance of this Agreement shall not terminate the rights or liabilities of either party arising out of a period prior to such discontinuance.

(d) Upon discontinuance of this Agreement, The Travelers upon request of the Contractholder shall complete the processing of all requests for benefit payments under the Plan, complete information necessary for payment as to which has been received by The Travelers prior to the date of discontinuance under the terms and conditions which would be applicable if this Agreement were still otherwise in full force and effect.

The Contractholder will be liable for all drafts issued by The Travelers within the terms of this Agreement during the continuance of this Agreement. All drafts issued by The Travelers which are outstanding upon the discontinuance of this Agreement or issued thereafter in accordance with the immediately preceding paragraph (d) will continue to be the responsibility and liability of the Contractholder. An Administration Charge will be made to take into account the benefit payment activity taking place after the date of discontinuance of this Agreement.

## Section IX: Examination of Records

The Contractholder shall have the right to examine any records of The Travelers relating to benefit payments and requests for benefit payments under the Plan and the issuing of drafts for payment of benefits under the Plan; provided, however, that any examination of individual benefit payment records shall be carried out in a manner agreed to between the Contractholder and The Travelers designed to protect the confidentiality of the individual's medical information.

## Section X: Assignment

No assignment by either party pertaining to this Agreement shall be valid without the consent of the other party.

## Section XI: Applicable Law

This Agreement shall be governed by the Laws of the State of Connecticut.

## Section XII: Amendments

This Agreement may be amended as mutually agreed to in writing by the parties at any time.

## Section XIII: Execution of Agreement

IN WITNESS WHEREOF, the Contractholder and The Travelers have caused this Agreement to be executed in duplicate by their respective officers duly authorized so to do.

| | |
|---|---|
| THE TRAVELERS INSURANCE COMPANY | CAP STAFFING, INC. |
| By______________________________ | By______________________________ |
| Dated at_______________________ | Dated at_______________________ |
| This______day of_________,1989 | This______day of__________,1989 |

# EXHIBIT A

TO

ADMINISTRATIVE SERVICES AGREEMENT

BETWEEN

CAP STAFFING, INC.

AND

THE TRAVELERS INSURANCE COMPANY

Employees Eligible and Plan Benefit Descriptions:

The Plan Benefit Descriptions are the Health Benefits described in the Cap Staffing, Inc. Summary Plan Descriptions for all Eligible Employees.

EXHIBIT B

TO

ADMINISTRATIVE SERVICES AGREEMENT

BETWEEN

CAP STAFFING, INC.

AND

THE TRAVELERS INSURANCE COMPANY

## ADMINISTRATIVE SERVICES OF THE TRAVELERS

1. Benefit Entitlement Determination

(a) During the continuance of this Agreement, all requests for benefit payments under the Plan shall be made to The Travelers on forms satisfactory to The Travelers. The Travelers will determine the entitlement to Plan Benefits as to any request for benefits in accordance with the Plan and The Travelers benefit cost control standards and procedures and practices applicable to benefits under the Plan.

(b) The Contractholder and The Travelers shall agree upon procedures through which the eligibility of an employee or dependent for benefits under the Plan shall be determined.

(c) With respect to any person who makes a request for Plan benefits which is denied, The Travelers will notify said person of the denial and of his right of review of the denial, in a manner agreed to between the Contractholder and The Travelers designed to satisfy the requirements of the Employee Retirement Income Security Act of 1974 (P.L. 93-406).

2. Benefit Payments

Whenever The Travelers determines that benefits are payable under the Plan, The Travelers shall issue a draft in payment of such benefits which, subject to acceptance by The Travelers, and subject to the terms and conditions of this Agreement, shall be paid from the Contractholder's bank account, as set forth in Section V.

3. Plan Benefit Development

The Travelers shall provide services in connection with the design and development of the Plan, both initially and in connection with revisions to the Plan, including

(a) underwriting and actuarial services, including estimates of Plan costs and costs of potential Plan revisions.

(b) Preparation of Plan benefit description.

4. Plan Benefit Booklets

Subject to the Contractholder's review and concurrence, The Travelers shall prepare benefit booklets for distribution to covered employees. The Contractholder and The Travelers will include in the Plan booklet the necessary Plan Description information as may be required under the Employee Retirement Income Security Act of 1974 (P.L. 93-406).

5. General Administration

The Travelers Group Field and Home Office personnel will be available to assist the Contractholder in connection with the general administration of the Plan, including assistance as to the enrollment of eligible persons under the Plan and administration and record keeping systems for the ongoing operation of the Plan.

6. Privilege of Obtaining an Individual Policy of Insurance Under Certain Conditions

During the continuance of this Agreement, The Travelers will make individual policies of insurance available subject to the conditions of Exhibit B-1.

7. The Travelers shall maintain all benefit payment records as to requests for benefits for a period of four years following the month in which final benefit payment was made as to a benefit file. In the event of discontinuance of this Agreement, any such records in possession of The Travelers shall be forwarded to the Contractholder as soon as there is no further need in connection with the services performed by The Travelers.

8. Plan Reports

The Travelers shall prepare the following reports as to the Plan:

(a) The Travelers shall make the necessary reporting to the United States Internal Revenue Service as to payments made to physicians and other medical care providers.

(b) The Travelers shall provide the Contractholder with reports as to information available to The Travelers and required to be provided annually as to the Plan, in accordance with the Employee Retirement Income Security Act of 1974.

(c) Other reports as applicable to Contractholder.

## EXHIBIT B-1

## PRIVILEGE OF OBTAINING INDIVIDUAL INSURANCE

1. Subject to the limitations stated in paragraph 3, The Travelers agrees to provide to Employees and certain Dependents of Employees of the Contractholder, a privilege to obtain a policy of individual health insurance, without a showing of evidence of insurability, in the event that the Employee or Employee's Dependent ceases to be eligible for health benefits under the terms of the Plan due to the following events:

   (a) termination of Employee's employment in the classes eligible for health benefits,

   (b) death of the Employee while the Employee's Dependents are covered under the Plan,

   (c) with respect to a child of the Employee, due to such child ceasing to be a Dependent, as defined under the Plan, or due to termination of the Employee's employment in the classes eligible for such benefits provided such child has attained the age of nineteen, or

   (d) with respect to the Employee's wife or husband, due to the termination of his or her marriage to the Employee.

2. Subject to the limitations stated in paragraph 3, The Travelers agrees to provide to former Employees and certain Dependents of Employees or former Employees of the Contractholder, a privilege to obtain a policy of individual health insurance, without a showing of evidence of insurability, if the former Employee's or Dependent's coverage has been continued pursuant to Title X of Public Law 99-272, at the end of the period of continuance, to the extent required by said law.

3. In order to obtain the policy of individual health insurance the Employee and/or the Employee's Dependents must make application to The Travelers and pay the initial premium for said policy within Thirty-one (31) days after the termination of coverage under the Plan. However, The Travelers shall be under no obligation to provide a policy of individual health insurance in the event that the Employee or Dependent becomes eligible under the Plan during such Thirty-one day period. Other limitations which apply to the privilege provided in paragraph 1 and 2 are as follows:

   (a) The individual policy shall not cover the Dependents of the Employee unless the Dependents were covered under the Plan at the time of the termination of the Employee's eligibility under the Plan or the period of continuation described in paragraph 2.

   (b) No such individual policy shall be issued to a Retired Employee unless he or she ceases to be included within the term "Retired Employee" as defined under the Plan.

(c) If the benefits applicable to any person under the Plan are less than the benefits provided under the individual policy of health insurance, issuance of such individual policy shall be subject to the underwriting rules of The Travelers for the issue of individual policies.

(d) If any other coverage (group or otherwise) for hospital expenses or service is in force or has been requested or applied for with respect to any person for whom coverage under such individual policy is requested, The Travelers may (a) decline to issue such individual policy if such other coverage was not in force prior to the termination of the Employee's benefits under the Plan, or (b) limit the benefits under such individual policy if such other coverage was in force prior to the termination of the Employee's benefits under the Plan.

4. The form of any individual policy issued pursuant to this provision, the coverage thereunder, and all other terms and conditions thereof shall be provided by the rules of The Travelers for such individual policy at the time of such application. The effective date of an individual insurance policy issued pursuant to the foregoing provisions shall be the date of termination of coverage under the Plan.

5. In event of the death of an Employee whose Dependents were covered under the Plan, during the Thirty-one day period allowed hereunder for making application for an individual policy and before any such individual policy shall have become effective, the Employee's Dependents shall have the privilege of obtaining an individual policy on the basis and subject to the conditions herein before indicated.

# EXHIBIT C

# TO

# ADMINISTRATIVE SERVICES AGREEMENT

# BETWEEN

# CAP STAFFING, INC.

# AND

# THE TRAVELERS INSURANCE COMPANY

## DUTIES OF THE CONTRACTHOLDER

1. The Contractholder shall provide The Travelers on a timely basis with such information as to the employees and dependents covered under the Plan as will be necessary for The Travelers to determine eligibility as to requests for Plan benefits, and to provide Plan cost estimates and reports as set forth in Exhibit A.

2. The Contractholder shall provide The Travelers with such information as to the Plan benefits as will enable The Travelers to determine benefits payable under the Plan and to prepare the Plan benefit booklet for distribution to employees. The Travelers and the Contractholder shall endeavor to complete preparation of the Plan benefit booklet so that such booklet may be distributed prior to the effective date of the Plan. If the Plan benefit booklet is not distributed prior to such date, the Contractholder shall deliver to each employee prior to such effective date written notification that as of the effective date of the Plan it has assumed liability for payment of Plan benefits and that Plan benefit payments will be administered by The Travelers.

Senate Permanent Subcommittee
on Investigations

EXHIBIT # 14

UNITED STATES SENATE

PERMANENT SUBCOMMITTEE ON INVESTIGATIONS

STATEMENT FOR THE RECORD BY NATIONAL STAFF LEASING ASSOCIATION

TUESDAY, MAY 15, 1990

# National Staff Leasing Association
# Written comments in lieu of
# ORAL TESTIMONY
# BEFORE THE PERMANENT INVESTIGATING COMMITTEE
# OF THE UNITED STATES SENATE

MAY 15, 1990

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

I am Morgan Hall, President of the National Staff Leasing Association, the organization representing employee leasing firms throughout the nation meeting strict self-imposed requirements for fiscal and ethical business practices. I am also founder and chief executive officer of TFE, Inc., one of the oldest and largest employee leasing firms. While our corporate headquarters is located in Georgia, our company has provided two thousand employees to a variety of companies in 35 states since 1975. Some of those two thousand employees have been with TFE since its inception. In its fifteen year history, our firm has never missed one dime of a payroll, payroll tax deposit or benefit payment. Over its history, these fulfilled obligations have exceeded 300 million dollars.

On behalf of the National Staff Leasing Association, I am pleased to have the opportunity to bring to the committee's attention, important facts about an industry that is growing about 30% annually. I am not at all pleased that it is the necessity for this hearing that provides the opportunity for such a presentation.

I wish to present the following points to the Committee for the record.

1. The employee leasing industry is a market driven response to the needs of many thousands of small businesses and their employees. We make available sound and valuable benefit programs, including health

insurance and pensions which might otherwise be unavailable or unaffordable. We also provide human resource services and administrative guidance to keep our clients in compliance with ever increasing state and federal legislation and regulation.

2. The National Staff Leasing Association represents members who recognize their fiscal responsibility to both their employees and clients. Having recognized these responsibilities, our member firms have developed and adhere to a code of ethics which requires them to submit to quarterly, independent, external CPA audits to prove these responsibilities are being met. These audits confirm that all payroll taxes have been deposited in a complete and timely fashion; that all benefit obligations have been properly funded in a timely manner; and that all required insurance, including workers' compensation, is current and in force. A copy of the NSLA's Code of Ethics, which summarizes these requirements, is attached hereto.
3. It would be unfortunate and wrong to tarnish a young, growing and needed industry because of the inappropriate actions of the few who always garner the headlines.
4. Our concern about these matters is not new. Over the years, the NSLA has worked with and supported the government's efforts to ensure that working Americans receive the benefits to which they are entitled.

There are today an estimated 300-400 employee leasing firms across the nation. Of those, 130 are members in good standing of the NSLA and responsible for an estimated 50% of all leased employees.

The industry today covers approximately 500,000 employees, up from only about 100,000 just three years ago. Employee leasing frees up businesses to concentrate more directly on the mission of their companies. It also serves to enhance compliance with and understanding of laws governing the employer/employee relationship.

Mr. Chairman and Members of the Committee, the scope of the alleged improprieties of one company which are the subject of today's hearing should receive the attention of this Committee. We welcome and support your efforts. If the allegations are correct, those responsible should be prosecuted to the fullest extent of the law, as should anyone who commits fraud.

At its inception, CAP Staffing applied for and was accepted for membership in the NSLA in August, 1988. We had no grounds on which to suspect or exclude them. As you know, excluding or terminating members is a serious process for a trade association given applicable anti-trust laws. The Association determined that CAP Staffing was not in compliance with our Code of Ethics in the fourth quarter of 1988 and subsequently terminated their membership in accordance with our bylaws.

It is not surprising that the various state officials who have come to these hearings are justifiably concerned. They will hopefully admit to you such concerns only arise when firms are doing something wrong. The far larger part of this industry certainly deserves to be recognized for the benefits it provides rather than being identified with these hearings which, again, we wholeheartedly support.

The NSLA is committed to working with these officials of every state, and have demonstrated that commitment clearly through appearances before virtually every major organization in the employment security and workers' compensation fields. The NSLA's leadership was asked to speak to hundreds of state and federal executives during 1987 and 1988 by the U.S. Department of Labor. And we have worked with ICESA and other multi-state organizations. The purpose was to clarify employee leasing and how the business is properly conducted. What we often find, however, is that much of the information previously available often deals with headline material arising when one or two firms in the business experienced, or created, serious problems.

As with many industries this one is maturing rapidly. Part of that maturation has been the evolution of the NSLA, our standards and the means by which we enforce them. We are extremely proud of the record of association members and the remarkably dedicated people who have invested of themselves to broaden the professionalism of the industry. And that is why we have pressed for proper regulation at both state and federal levels.

As you review testimony and your own research with an eye to potential regulation, you will find that the NSLA has already worked quite hard to encourage firm but fair regulation at the state level. We will likewise be privileged to work with the Committee and Staff to develop effective and workable proposals for Congressional consideration.

In closing, I respectfully urge, Mr. Chairman, that you and your colleagues permit our industry association's leadership to work with you and your staffs to clarify rules which govern the industry to the end that small business firms and their employees together can enjoy reliable benefit programs. Today's hearing notwithstanding, legitimate employee leasing is a very cost effective method of expanding health care coverage to America's small businesses. This is the workplace where two-thirds of those who are employees, but do not have health coverage, can be found.

On behalf of the officers, directors and members of the NSLA, I thank you for this opportunity to present this brief background.

Respectfully submitted by

L. Morgan Nall, III
President
National Staff Leasing Association

# NSLA Code of Ethics

OBJECTIVES: The purpose of the NSLA Code of Ethics is to establish ethical standards that are required of all members of the National Staff Leasing Association. This Code is also prescribed to establish minimum levels of conduct required of every firm who chooses to join the NSLA.

ONE: Members shall recognize that they must serve the public and their clients with the utmost professional conduct. In this respect, a member shall endeavor to pursue the public interest above its own.

TWO: Members shall comply with all applicable federal, state, and local laws and regulations. No member's business shall allow unlawful discrimination among its employees or clients on grounds of race, sex, national origin, religion, handicap,or any other unlawful basis.

THREE: Members shall remain informed on issues essential to the conduct of their business and seek the expertise of competent professionals when handling difficult questions or situations. Members shall comply with the NSLA's continuing education requirements.

FOUR: Members shall assist and serve the best interests of employees on their payroll. Members agree to cooperate with each other for the assistance of their clients and employees.

FIVE: Members shall assist in improving the public understanding of staff leasing. To that end, members shall neither disparage nor engage in conduct that could jeopardize the welfare of the NSLA or its members.

SIX: Members shall:

(a) contract in writing with their clients to provide services and personnel;

(b) contract and agree with their clients on employee wage rates;

(c) be the employer of record responsible for paying the wages of leased employees from the members' own account(s);

(d) reserve a right of direction and control over leased employees, including a right to hire and fire;

(e) be responsible for the collection, payment, and reporting of withholding, payroll, unemployment, and similar taxes to appropriate governmental agencies;

(f) cover leased employees under a workers' compensation policy or account on which the member is a named insured, or has received an alternate employer endorsement, pay the premiums on said policy or account, and administer the claims against said policy or account, unless otherwise regulated by law;

(g) provide and administer benefit programs as contracted and agreed with their clients, and comply with laws regulating the provision, administration, and reporting of said benefits;

(h) maintain both adequate and required employment-related records for leased employees, and report such information as may be required by or to appropriate governmental agencies for leased employees;

(i) submit a quarterly statement to the NSLA from an independent CPA or PA which indicates that all tax deposits have been timely made;

(j) submit a quarterly statement to the NSLA by the member's CEO certifying that all employee benefits payments have been timely made;

(k) submit to the NSLA a certification of workers' compensation insurance.

SEVEN: Members shall use the fact of membership in the NSLA in a professional manner that is consistent with this Code of Ethics.

EIGHT: A violation of the Code of Ethics will be subject to review by the NSLA's Board of Directors and can result in suspension and/or termination from membership in the NSLA. Such suspension or termination will be published to the membership.

Senate Permanent Subcommittee
on Investigations
EXHIBIT # 15

UNITED STATES SENATE
PERMANENT SUBCOMMITTEE ON INVESTIGATIONS
STATEMENT FOR THE RECORD BY BEDFORD H. BERREY, M.D.
NATIONAL ALLIANCE OF SENIOR CITIZENS, INC.
TUESDAY, MAY 15, 1990

**NATIONAL ALLIANCE OF SENIOR CITIZENS, INC.**

**National Headquarters:**
2525 Wilson Boulevard / Arlington, Virginia 22201 / (703) 528-4380

**Mrs. Virginia Aubrey**
**President**

**C.C. Clinkscales, III**
**National Director**

3 May 1990

RECEIVED BY
SENATE PERMANENT
SUBCOMM ON INVESTIGATIONS
MAY 06 1990
MAJORITY OFFICE

Honorable Sam Nunn
Chairman,Permanent Subcommittee on Investigations
Committee on Governmental Operations
United States Senate
Room 100, SROB
Washington,D.C.,20510.

Dear Senator Nunn:

The National Alliance of Senior Citizens, Inc., has a sustained interest in the health and welfare of all elderly Americans. Available, affordable and reliable health insurance is of paramount concern to our members.

We are encouraged by the cover story in USA TODAY (30 April 1990) wherein you are reported to hold hearings on alleged health plan fraud, on 14-15 May 1990. The fact that fraud is alleged to exist in the health insurance industry is sad and serious. Without question it deserves the attention you are directing. The NASC applauds your effort.

Whatever your subcommittee finds in health care insurance that can be considered fraudulent a barrier to effective corrective action exists.

The McCarran-Ferguson Act(1945) provides broad immunity to the whole of the insurance industry from prosecution under federal anti-trust statutes. Such immunity may act to embolden some purveyors of health insurance in their zeal to sell health care insurance of dubious value to subscribers.

In January 1987, Senator Howard Metzenbaum introduced S 80(A Bill to Repeal McCarran-Ferguson Act).Hearings were held by the Committee on the Judiciary in early 1987. Beyond that I am unaware of further action on S 80.

The NASC urges the subcommittee to focus attention on the fact that immunity from federal anti-trust prosecution may well play a major role in what the subcommittee has under investigation. The fact that state insurance officials have the authority to regulate insurance companies within their respective atates may prove to be insufficient to police the industry absent federal anti-trust authority.

The National Alliance of Senior Citizens,Inc.,respectfully requests that this letter be included in the official transcript of the subcommittee hearings.

Cordially yours,
Bedford H Berrey M.D.
Bedford H. Berrey,M.D.
Medical Director

Copy:
Honorable William V.Roth,Jr.

Senate Permanent Subcommittee on Investigations

EXHIBIT # 16

Affidavit of David B. Bias of Fayetteville, North Carolina to the US Senate Permanent Subcommittee on Investigation SR 100.

My name is David B. Bias. I am a self-employed insurance agent licensed with Mutual of Omaha and doing business in the state of North Carolina. I was first approached about CAP Staffing in July 1988 by Gray Renegar who was my manager at Mutual of Omaha. He and his son, Michael, were involved with CAP Leasing prior to becoming involved with CAP Staffing. I was only involved with CAP Staffing. A meeting was held in Fayetteville for anyone who was interested in CAP Staffing in the October/November 1988 time frame. I was invited along with a number of other insurance agents (30-40 total). The majority of agents were veterans with at least ten years in the industry. Some were Charter Life Underwriter (CLU) qualified. I had one and one-half years of experience as an insurance agent at this time. The primary speakers were Robert Long (President-CAP Staffing, CAP leasing, and CAP Programs), Ron Harris (Insurance Director for CAP Staffing), and Rick Stamey (CAP Staffing Representative). I do not think anyone from Travelers was in attendance for this meeting but Stamey said a representative did attend meetings in Charlotte. Long explained employee leasing and the potential it offered. Harris explained the insurance portion of the leasing plan. He used Travelers literature showing a Major Medical plan with a $100 deductible/$1000 Out-of-pocket. We were told by Long and Harris that Travelers had given CAP a good rate because of the large number of employees under the plan. There was no indication that this was anything other than a fully insured plan offered to leased employees. This plan gave the small employer the way into a top employee benefit plan that would not be available otherwise. Strong sales point. The rates that were given were below the normal market for small business but not below true group quotes. Harris was presented as a former Travelers executive by Long which supposedly gave CAP an inside track for this plan. Nothing was ever said that would indicate that this was plan under a 501C Trust or any other Multiple Employer Plan. I would not have known what a Multiple Employer Plan or Trust was at that time. I learned that after the fact or because of it. Long told us you had to be an insurance agent to be able to sell the leasing package. I think we all assumed that this was a plan governed by the State Insurance Department because of the presentation. Stamey then gave some examples of companies that he had sold and his technique in doing his presentation.

We were told that there were two plans offered by CAP Staffing. One a full service and the other an administration only. The full service plan contained payroll services, insurance, employee relations, employee handbook, etc. The administration service provided anything but payroll, i.e. Section 89 compliance, employee screening, etc. Section 89 compliance was accomplished because the employees no longer belonged to the employer but were now leased and it was the leasing company's (CAP Staffing)problem. So those companies that wanted to discriminate or were top heavy could pool their employees in a larger pool, thereby complying with Section 89. A lot of companies were worried about Section 89 at this time. Fees were based upon the plan chosen. The full service was percentage of payroll and start-up fee. The administration fee was normally ten dollars per person on the insurance plan with a $25 per person set-up fee. These fees proved to be negotiable.

Gray Renegar and I put the first group (Archer Trim, Inc.) on the full service plan for our area in December 1988. I followed it with nine admin only groups. These were groups that for the most part had problems qualifying for fully insured plans. Some were in restricted industries, some lacked employer participation in the plan, and some had medical problems.

There were problems from the beginning but we all attributed them to growing pains. Some of the problems were slow or no billing, lack of employee handbooks, and slow claims. Claims started being paid and the books came in March 1989. The books came from Travelers and again caused us to believe that we had a fully insured plan. I looked at page one of the handbook and saw that it said "insured by the Travelers Insurance Company". It also states that "the Travelers Insurance Company has issued Group Policy No. G and GA-118203 covering certain Employees of the Employer". No one I know paid any attention to page 14 of the Handbook until after Travelers terminated the policy. Things appeared to be going well. Around the end of May 1989 we heard that someone from Florida was coming in to take over CAP Staffing. Long had said all along that he was not a manager and he had proved it. So it was thought that this would help stabilize the company. A letter came out in June 1989 stating that Mike Spieles was now the President of CAP Staffing. The letter was from Spieles. The office personnel at CAP Staffing said Spieles came in the office and stated that he was now in charge. Long was moved to franchise sales and Harris let go. Other people were rearranged in the Charlotte office. Some investors went to Florida to meet with Spieles and came back encouraged that their investments would be honored by Spieles. I believe these were investors in CAP Leasing or CAP Programs. The State Attorney General for North Carolina should have a list of the investors. He asked me for input at one time so I assume he obtained a list of investors. The second week of August 1989 brought a call to me from one of my clients that the hospital had called Travelers and was told that coverage had been terminated by Travelers on 1 August 1989. I called CAP and it was confirmed by Maria Pauley. After asking why we were not notified, I was told that Universal Staffing was going to take over. Spieles had cancelled his contract with Long and was starting Universal Staffing Associates (USA) and would take all CAP clients with no break in coverage. Later I found out from Steve Loflin in Greensboro, NC that Travelers had sent a termination letter to Harris in June 1989. He was not employed by CAP at that time. We had a number of companies with payroll lost and no insurance coverage so USA became the only way to go. This was their only option because many had medical problems or were going to have claims in the near future. A new insurance carrier would not take groups in that situation. The lack of a claims loss record also limited new carriers because many require a previous loss record before issuing coverage to a new group.

Stamey made a trip to Florida to see how and if USA was going to be able to do things right this time. He was shown documentation that gave every indication that USA was going to do things according to the law. They said that previous CAP clients could stay at the same rates for four months then they would be given a new rate effective in 60 days. We were going to be able to do both admin and full service. This later became impossible, but it gave us 6 months to move the groups to another carrier. USA went to National Benefit Coordinators (NBC) to obtain insurance coverage for both plans. NBC attempted to put both plans in one trust and found out this was not legal. They then attempted to make an association of some type to handle the admin only clients. We were told through Stamey that this was not possible and the only way to be legal was to go under the full lease package.

Overall I did not find out that Travelers was not the insurer until the policy had been terminated. Most of what I found out was through Stamey and Loflin the end of August 1989. I became aware of some employee leasing organizations that were doing it right and still are. A lot of people were hurt by CAP Staffing. The claims that were not paid, commission not paid, the time wasted, and the reputations lost are a few of the hurts. Those of us that were agents have lost clients, our reputations, and commissions plus almost two years out of our career.

I feel that Travelers is still obligated to pay claims. It is my understanding that they paid out more than they took in from CAP. If they allowed CAP to not fund the trust and still continued to pay claims then all claims to August 1, 1989 should be paid by them. Also if its true that Travelers employees attended training meetings for CAP representatives and did not correct the misunderstanding of the true plan, then they again are at fault. Travelers should have allowed the groups under CAP to obtain coverage through one of their regular plans when the CAP plan was terminated.

Sworn to and subscribed to before me this 11th day of May 1990.

Subscribed and sworn to before me this 11th day of May 1990.
My commission expires September 30, 1990

A. Louise Perry

Address 6006 Ruggles Ct. Fayetteville, NC 28314 SEAL

Senate Permanent Subcommittee
on Investigations

EXHIBIT # 17

UNITED STATES SENATE

PERMANENT SUBCOMMITTEE ON INVESTIGATIONS

STATEMENT FOR THE RECORD BY RON HAMM, ARCHER TRIM, INC.

TUESDAY MAY 15, 1990

**ARCHER TRIM, INC.**
P. O. Box 1544
State Road 2209
Lumberton, N. C. 28359
(919) 739-2436

Mr. David Buckley
Chief Investigator
U.S. Senate Permanent Sub-Committee
on Investigations
(Chairman: Sen. Sam Nunn)
Washington, D.C. 20510

Gentlemen:

In October of 1988, United of Omaha (the health care division of Mutual of Omaha) notified us of an impending rate increase. Our premiums were to increase to 270% of their 1988 level as of January, 1989.

Our agent, David Bias, suggested we look into using an employment service as a means of securing insurance at affordable rates. While we did not want to assign our employees to a service, we agreed to pay a fee to have our payroll processed and receive insurance coverage from Cap Staffing. This arrangement worked well during the seven month period Cap Staffing provided us with coverage. It should be noted that all the claims were small and were paid by Travelers Insurance.

Our problems began in August, 1989 when Cap Staffing was acquired by Universal Staffing Associates. We were told by David Bias that Universal Staffing would honor Cap Staffing's commitment to provide us with coverage for five months. We continued to pay premiums in the amount billed to us by Universal Staffing Associates and filed medical claims with National Benefits Consultants as instructed.

In December, 1989, our employees began complaining that their claims were not being paid. I contacted Janice at National Benefits Consultants. She told me that no one at Universal Staffing has authorized payment of our claims.

In January, 1990, I was contacted by Carla Erdmann of Universal Staffing. She informed me that our premiums for August and September had not been paid resulting in a delay in claim payments. I then sent copies of the cancelled checks for the premium payments in question. These checks had been deposited in one of Universal's accounts in Florida. It was then discovered that Universal had billed us incorrectly resulting in a balance due of $158.40. We immediately issued a check for that amount and mailed it to Universal. Ms. Erdmann then informed us that our account was in good standing and that claim checks would be issued. After waiting thirty days, I again contacted Janice at National Benefits Consultants. She said she had still not received authorization from Universal to issue claim payments. I immediately called Ms. Erdmann who checked our file and could find no problem. She said she would discuss it with her supervisor, Fred Heilbronner, and call me back as soon as possible. After waiting several hours for a reply, I again called and was informed by the switchboard operator that Ms. Erdmann would not take my call. She also said that I would be receiving a letter explaining everything, a copy of which is attached.

On or about March 30th, 1990, I received a second letter (from Mr. Micheal H. Spieles). A copy of this letter is also attached. To the best of my knowledge, no claims under the Universal Staffing program have been paid to date.

Ron Hamm

Ron Hamm

Plant Manager

**Universal Staffing Associates™**
4125 SW Martin Hwy., Palm City, FL 34990
407/220-6800. 800/STAF USA. 407/288-4228 - Fax #

February 7, 1990

Dear Insurance Customer:

National Benefits Consultants (NBC) and our main office have received numerous communications, via both telephone and mail, concerning payment of claims. I would like to take this opportunity to clarify Universal Staffing's position on claims payments.

Universal Staffing recognizes its obligations to pay eligible claims and will make all appropriate claim payments, as it already has in hundreds of cases. Claim payments will be made in the near future in the order in which they are processed and cleared for payment. No claim payments will be made on accounts with any outstanding balances due.

Unfortunately, we do not have a large enough staff of personnel available to both process claims and answer inquiries concerning claims payments. Calls concerning claims payments do not in any way speed up their ultimate payment. In fact, because they interrupt our work flow, they tend to slow the flow of payments. Consequently, our staff will no longer accept calls concerning payment of claims. Please do not feel slighted when your call is handled at the switchboard, but we must enforce this policy in order to be efficient and productive. Additionally, NBC will also not accept these types of inquiries.

If any insured person is having difficulties with providers and/or collection agencies demanding payment, the insured may refer the provider or collection agency directly to us. We will attempt to handle the matter from there.

Sincerely,

Fredric D. Heilbronner
Vice President Finance

**Universal Staffing Associates™**
4125 SW Martin Hwy., Palm City, FL 34990
407/220-6800, 800/STAF USA, 407/288-4228 - Fax #

March 14, 1990

To All Universal Staffing Associates Customers, Employees, and Agents:

The existence of insurance and payroll related problems in North and South Carolina have been brought to my attention. Therefore,I have ordered all employee leasing operations to cease in these areas effective March 15, 1990.

The underlying cause for making this decision is the high losses the Company sustained on the insurance portion of accounts during the period August 1 through November 30, 1989. USA is a new business venture and was capitalized as such. Unfortunately, the insurance losses overwhelmed the Company. USA is now technically insolvent. Additionally, due to the loss of our re-insurance carrier for our health insurance, all health insurance coverage has been cancelled effective March 1, 1990.

New financing is currently being arranged. All eligible insurance claims will be paid for accounts in good standing. Additionally, any bank fees caused by USA and incurred by employees or customers will be paid by USA. However, no claims or fees will be paid for those accounts which are in arrears. The time frame for making these payments should be not less than 60 nor more than 120 days. Any inquiries from health providers and/or collection agencies during this time period should be directed to the Company in **writing** for resolution. We will provide information as appropriate.

We hope this answers any questions you may have.

Sincerely,

Michael Spieles

Michael H. Spieles
President

Senate Permanent Subcommittee
on Investigations

EXHIBIT # 18

NBC INC.
National Benefit Consultants, Inc.
P.O. Box 19035
Green Bay, Wisconsin 54307-9035
(414) 496-2500

STATEMENT OF MR. ROBERT J. HERGENRADER

SUBMITTED FOR THE RECORD BEFORE THE U.S. SENATE PERMANENT SUBCOMMITTEE ON INVESTIGATIONS

MAY 15, 1990

Mr. Chairman and Members of the Subcommittee, my name is Robert J. Hergenrader of National Benefit Consultants. I am pleased to assist the Subcommittee in its investigations into multi-employer welfare arrangements, and the abuses that can occur in some of those programs. My company, a health care insurance administrator, was the victim of abuse of these programs.

In order to share as much information as accurately as possible, I have organized my material on a monthly basis and will relate the situations in chronological order.

## JULY / AUGUST, 1989

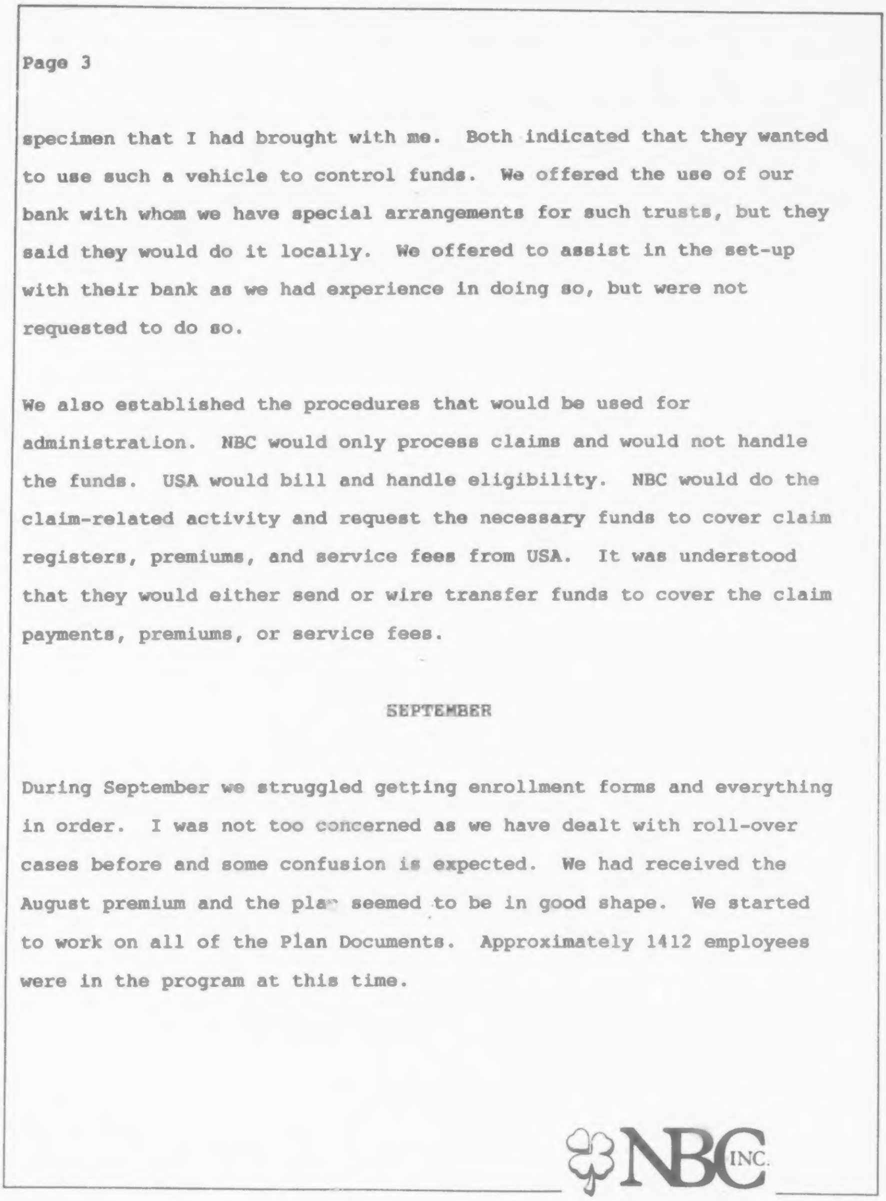
In late July I received a call from Dave Erdman. My name had been given to Dave by aquaintances of his in Green Bay who were aware of my company and the services we provide (third party administration.) I was also familiar to Dave in that he and his family are natives of Green Bay and I had worked with his wife, Carla, at Wisconsin Employers Insurance Co. located in Green Bay.

Dave indicated to me he was working for an employee leasing firm - Universal Staffing Association (USA) - related to me that he had groups of 2000+ employees and wondered if I could help them secure stop-loss coverage.

We discussed the program and he informed me of the previous situation of CAP Staffing and that these were "roll-over" employees from that program. Early in August, I received a competitive bid from a Lloyds of London correspondent, presented a proposal, and received the go-ahead from Dave.

After the acceptance, we needed to enroll the group in order to issue ID cards, etc. We had trouble getting data since these employees were scattered and the "roll-over" of benefits is more difficult than writing new lives. We worked off employee lists and were asked to wait for the true enrollment cards until they were entered into the payroll system. I arranged to go to Florida in late August (23-25) to meet all of the principals and to "set-up" the administration.

At our first meeting I met Mike Spieles, the owner, and other key individuals that were to form the management team of USA. During this first meeting, we discussed in great detail how CAP Staffing "abused" the system. We discussed ERISA and how to handle money properly to avoid fiduciary problems. I met with Mr. Spieles and his in-house attorney specifically to go over a sample 501 (c)(9) trust



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specimen that I had brought with me. Both indicated that they wanted to use such a vehicle to control funds. We offered the use of our bank with whom we have special arrangements for such trusts, but they said they would do it locally. We offered to assist in the set-up with their bank as we had experience in doing so, but were not requested to do so.

We also established the procedures that would be used for administration. NBC would only process claims and would not handle the funds. USA would bill and handle eligibility. NBC would do the claim-related activity and request the necessary funds to cover claim registers, premiums, and service fees from USA. It was understood that they would either send or wire transfer funds to cover the claim payments, premiums, or service fees.

SEPTEMBER

During September we struggled getting enrollment forms and everything in order. I was not too concerned as we have dealt with roll-over cases before and some confusion is expected. We had received the August premium and the plan seemed to be in good shape. We started to work on all of the Plan Documents. Approximately 1412 employees were in the program at this time.

NBC INC.

On September 18th & 19th I flew to Charleston, S.C. to hold a meeting with the agents and to explain the new benefit plans. Later that week Hurricane Hugo hit the South and confusion reigned. Our efforts to complete our enrollment were hampered by the confusion over Hugo.

We were now, however, beginning to receive more information on the program and began to analyze the enrollment. I informed USA that the rates they were using, which were the old Cap Staffing rates, were grossly inadequate and were at approximately 35% - 40% below the normal rate that should be charged for the benefits. They indicated that USA could not raise the rate because they had promised the agents/clients not to adjust it to assist in the transfer from Cap Staffing to USA. It was at this time that I also became aware & advised Mr. Spieles that they were possibly in violation of statutes pertaining to ERISA, M.E.T.'s, and MEWA's. I discovered that they were covering employers without leasing their employees. In other words, you could either lease and insure your employees, or just insure them. I offered to review this further.

Money was now becoming an issue. I was continually asking Fred Heilbronner for money but was told, "It's there, but we don't want to pay you anymore than absolutely necessary because of poor cash flow." In light of the roll-over problems and Hurricane Hugo, etc. that seemed like a reasonable situation and we took only enough funds to maintain the minimum premium.

## OCTOBER

On October 23, I wrote the attached letter to Mr. Spieles informing him of my findings concerning the status of the group. I flew to Florida and discussed how to handle the situation and they agreed to terminate all groups that did not have leasing arrangements. We had further discussions, primarily with Fred over money, and that we needed funds to cover processed claims, etc.

## NOVEMBER

We continued to process claims in November and they (USA) were to be advising the employers to either join the leasing firm or they would have to give up their insurance.

## DECEMBER

In early December, I had been asked by the Executive Staff of USA to investigate the possibility of self-funding their Workers Compensation program. I and two other individuals made a trip to Florida to discuss that program. I asked them for payments to cover a minimum of the Lloyds premiums as Lloyds was going to terminate USA if premium was not received. USA gave me premium for September, October, and November. I forwarded this to Lloyds and Lloyds was still upset as they wanted the December premium also. I relayed this information to USA.

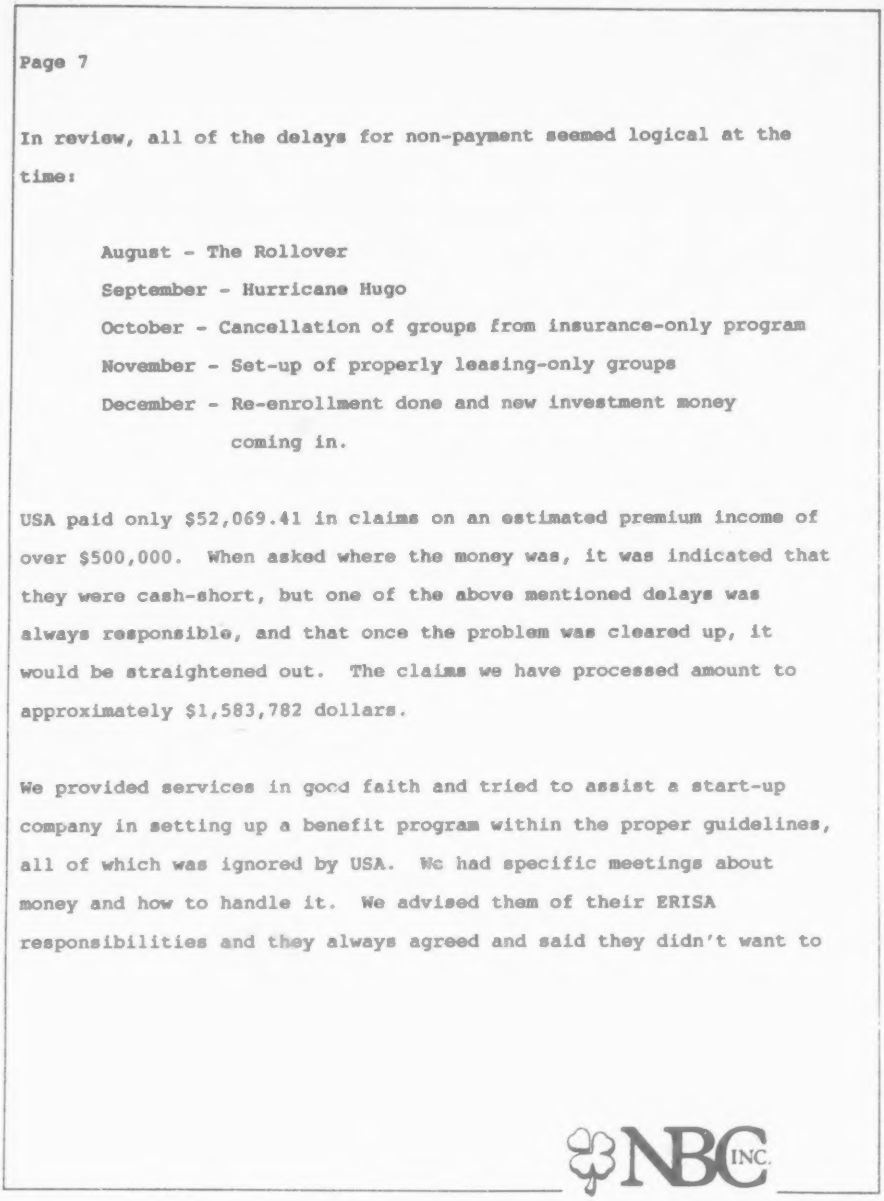
During this visit they began to talk about "new" money coming into USA and how this money would be used to clean-up the insurance program.

## JANUARY

We are finally beginning to arrive at the true figure of insured lives - the December enrollment has gone from over 1200 lives to only 184. It now dawned on me that we could have a problem. We began to demand payment of all premiums, fees, and claim funds. They issued checks to me, one for $41,738.65 and another for $36,407.77, in partial payment of outstanding obligations. Both were post-dated and they indicated that they would be good as new funding was expected in January or early February.

## FEBRUARY

Both of the above checks bounced and we realize that we had been had. We stopped all services and indicated such to USA. I received a FAX with a timetable for payment from USA, but that has been ignored also.



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In review, all of the delays for non-payment seemed logical at the time:

August - The Rollover
September - Hurricane Hugo
October - Cancellation of groups from insurance-only program
November - Set-up of properly leasing-only groups
December - Re-enrollment done and new investment money coming in.

USA paid only $52,069.41 in claims on an estimated premium income of over $500,000. When asked where the money was, it was indicated that they were cash-short, but one of the above mentioned delays was always responsible, and that once the problem was cleared up, it would be straightened out. The claims we have processed amount to approximately $1,583,782 dollars.

We provided services in good faith and tried to assist a start-up company in setting up a benefit program within the proper guidelines, all of which was ignored by USA. We had specific meetings about money and how to handle it. We advised them of their ERISA responsibilities and they always agreed and said they didn't want to

NBC INC.

do what Cap Staffing did. My company has not been paid since August, 1989 and has lost over $43,368.55 in administrative income, not including my time and expenses, plus substantial loss of reputation in the operating territory of USA.

R Hergenrader
ROBERT J. HERGENRADER
President and Chief Executive Officer

5-14-90
Date

NBC INC.

NBC INC.

**NATIONAL BENEFIT CONSULTANTS, INC.**
1150 Springhurst Drive, Suite 140
P.O. Box 19035
Green Bay, WI 54307-9035

Telephone: 414-496-2500
Fax: 414-496-2515
Wisconsin: 800-236-2515
Nationwide: 800-334-7504

October 23, 1989

Mr. Mike Spielas
President
Universal Staffing Associates, Inc.
4125 SW Martin HWY
Palm City, FL 34990

Dear Mike:

I have recently been informed, through our legal counsel, that recent changes in policy within the DOL (Dept. of Labor) could eliminate our establishing a self-funded association plan.

The DOL has advised all State Departments of Insurance that, effective with this ruling, all MEWA (Multiple Employer Welfare Associations) are no longer covered by ERISA.

These trusts, no longer protected by ERISA, will come under the control of each State Insurance Department. They will be mandated to become licensed insurers, meeting all premium and reserving requirements necessary to maintain a solvent financial situation per the state's requirements.

It is our position that we should advise all employers who do not maintain a "full-service" contract with Universal Staffing that, effective December 1, 1989, they will cease to have coverage under the current conditions.

Should you have any questions on this matter, please don't hesitate to contact me.

Sincerely,

NATIONAL BENEFIT CONSULTANTS, INC.

RHergenrader

Robert J. Hergenrader
President

RJH/mek

cc: Mr. Anthony Higgins
Dept. of Insurance
NORTH CAROLINA

NATIONAL BENEFIT CONSULTANTS, INC.

**Senate Permanent Subcommittee**
**on Investigations**

EXHIBIT # 19

ADMINISTRATIVE SERVICES AGREEMENT

BY AND BETWEEN

CAP STAFFING, INC.

(HEREINAFTER REFERRED TO AS THE "CONTRACTHOLDER")

AND

THE TRAVELERS INSURANCE COMPANY
HARTFORD, CONNECTICUT

(HEREINAFTER REFERRED TO AS "THE TRAVELERS")

WHEREAS, the Contractholder has established an employee health benefit plan described in Exhibit A hereof (hereinafter called the "Plan") for certain of its employees and their dependents; and

WHEREAS, the Contractholder desires The Travelers to furnish the services set forth in Exhibit B hereof;

NOW THEREFORE, in consideration of the mutual promises contained in this Agreement, the Contractholder and The Travelers agree as follows:

## Section 1: Responsibilities of The Travelers and the Contractholder

(a) The Contractholder retains all final authority and responsibility for the Plan and its operation. The Travelers is empowered to act on behalf of the Contractholder in connection with the Plan only as expressly stated in this Agreement or as mutually agreed to in writing by The Travelers and the Contractholder. The relationship of The Travelers to the Contractholder is that of an independent contractor and nothing in this Agreement shall be construed as creating any other relationships.

(b) The Travelers shall discharge its duties under this Agreement with the skill, care, prudence and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use. The Travelers shall not be liable for any mistake in judgment or other action taken in good faith.

(c) The Contractholder agrees to hold The Travelers and its directors, officers and employees harmless from any and all claims, lawsuits, settlements, judgments, costs, penalties, and expenses, including reasonable attorneys' fees, resulting from, or arising out of or in connection with any function of The Travelers under this Agreement, unless it is determined that the liability therefore was the direct consequence of criminal conduct or fraud on the part of The Travelers or due to the failure of The Travelers to discharge its duties in accordance with this Agreement; provided, however, that the Contractholder shall remain liable for payment of all benefits under the plan.

## Section II: Claims Administration

(a) The Travelers shall promptly process claims for plan benefits and calculate the amount due and payable and make payment or issue a denial notice. Any comments or written requests for appeals of denied claims shall be forwarded to the Contractholder for review and decision.

(b) In determining the benefits payable, if any, The Travelers shall exercise reasonable claim cost controls as described in Exhibit B.

(c) Whenever The Travelers becomes aware of an incorrect payment under the Plan, The Travelers shall make a diligent attempt to recover the amount incorrectly paid or will adjust the underpayment but The Travelers will not be required to initiate court proceeding for any such recovery.

(d) The Travelers may seek the services of experts in performing its duties under this Agreement. Should The Travelers do so without prior consultation with the Contractholder, any expense incurred shall be the responsibility of The Travelers. The Travelers shall consult with the Contractholder to legal counsel designated by the Contractholder when, in its judgment, legal to extraordinary Plan interpretation questions are involved.

(e) The Travelers shall advise the Contractholder as to matters which come to its attention involving potential legal actions which involve the Plan and shall promptly advise the Conractholder of legal actions commenced against the Contractholder which come to its attention. The defense of any legal action involving a claim for benefits under the Plan shall not be the responsibility of The Travelers under this Agreement. The Travelers shall fully cooperate with the Contractholder in the defense of any action arising out of matters related to this agreement.

## Section III: Tax Reimbursement and Payment

In the event that a state or other jurisdiction, in accordance with existing or future law, determines that The Travelers is liable for payment of taxes with respect to any aspect of the Plan, the Contractholder agrees to reimburse The Travelers for the amount of any such taxes, any interest expense assessed against or incurred by The Travelers before or after payment of such taxes, and any other charges, penalties or fines in connection therewith, including reasonable attorneys' fees, that The Travelers may sustain in connection with such taxes. Any such amount shall be due and payable upon written notification by The Travelers to the Contractholder.

The Travelers shall have sole discretion in determining whether any claim or assessment for taxes shall be paid, compromised, litigated or appealed and as to all matters of procedure, compromise, defense or appeal or any other aspects of any claim or assessment concerning its liability.

In the event that a state or other jurisdiction, in accordance with existing or future law, imposes upon The Travelers the duty to act as agent for collection of any tax imposed on the Plan or the Contractholder with respect to any aspect of the Plan, the Contractholder will pay over any such taxes to The Travelers when requested to do so by The Travelers.

The Travelers and the Contractholder each acknowledge and agree that, under the terms of this Agreement, payment of any applicable Texas administrative tax (as provided in Article 4.11 of the Insurance Code of Texas) which is based upon benefit payments or other amounts (other than fees actually paid to and received by The Travelers) is the sole responsibility of the Contractholder and that the Contractholder is responsible for collection and payment of such administrative services tax.

## Section IV: Duties of the Contractholder

In order for The Travelers to perform the benefit payment and other services for the Contractholder as set forth in Exhibit B to this Agreement, the Contractholder shall furnish to The Travelers certain information concerning the Plan and employees and dependents covered under the Plan as may from time to time be required by The Travelers as set forth in Exhibit C.

## Section V: Banking Arrangements

(a) During the term of this Agreement:

 (i) The Contractholder shall establish and maintain a bank account for the payment of benefits under the Plan in Connecticut National Bank, Hartford, Connecticut.

 (ii) All benefit payments made under the Plan will be issued by The The Travelers on drafts payable through Connecticut National Bank, Hartford, Connecticut.

(b) The Contractholder by this Agreement expressly authorizes The Travelers to issue and accept such drafts for benefit payments under the Plan on behalf of the Contractholder.

Drafts issued by The Travelers in payment of Plan benefits will, after presentment by the Bank to The Travelers and if in order, be accepted by The Travelers on behalf of the Contractholder and charged to said Contractholder bank account.

(c) The Contractholder agrees that it will, in accordance with arrangements agreed to between The Travelers and the Contractholder:

(i) provide to the bank funds for the payment of benefit payment drafts accepted by The Travelers under the Plan including withdrawal from any Special Account maintained by the Contractholder with The Travelers for the purpose of funding benefits under the Plan; and

(ii) maintain an amount as specified by The Travelers from time to time to the Contractholder on deposit with the bank equal to the total amount of drafts expected to be charged to the account during a 5 working day period.

## Section VI: Effective Date - Agreement Period

(a) This Agreement shall be effective as of November 1, 1988.

(b) The first Agreement Period shall be the period from the effective date to November 1, 1989.

(c) This Agreement shall be continued automatically, unless discontinued in accordance with Section VIII for successive Agreement Periods of twelve months each.

## Section VII: Administrative Service Charges

(a) Charges for the services set forth in Exhibit B shall be in accordance with the Schedule of Charges set forth in Exhibit D. Such charges and any applicable taxes imposed with respect to the charges shall be payable by the Trustees to the Travelers on or before the last day of each month.

(b) The Travelers shall have the right to change the Administrative Service Charge upon advance written notice to the Contractholder as of the first day of any month or as of the effective date of any amendment to the Plan or this Agreement which affects the Adminisrrative Service Charge except that no increase in the Administrative Service Charge, other than an increase due to a Plan amendment or amendment to this Agreement shall become effective prior to November 1, 1989 or thereafter prior to Twelve months after the effective date of any previous increase in such Charge.

## Section VIII: Discontinuance of Agreement

(a) This Agreement may be discontinued at the earliest time specified below:

(i) As of the date of discontinuance of the Plan, as specified to The Travelers by the Contractholder.

(ii) As of any date agreed to between the Contractholder and The Travelers.

(iii) As of the date the Contractholder fails to provide funds to the bank as necessary for the payment of drafts accepted by The Travelers on behalf of the Contractholder for benefit payments under the Plan.

(iv) As of the last day of an Agreement Period by either party giving thirty days notice to that effect to the other party.

(b) Application of this Agreement to any state or other jurisdiction may be discontinued by The Travelers or the Contractholder as of the date either party determines that it will be penalized for such state or other jurisdiction for proceeding with its performance under this Agreement.

(c) Discontinuance of this Agreement shall not terminate the rights or liabilities of either party arising out of a period prior to such discontinuance.

(d) Upon discontinuance of this Agreement, The Travelers upon request of the Contractholder shall complete the processing of all requests for benefit payments under the Plan, complete information necessary for payment as to which has been received by The Travelers prior to the date of discontinuance under the terms and conditions which would be applicable if this Agreement were still otherwise in full force and effect.

The Contractholder will be liable for all drafts issued by The Travelers within the terms of this Agreement during the continuance of this Agreement. All drafts issued by The Travelers which are outstanding upon the discontinuance of this Agreement or issued thereafter in accordance with the immediately preceding paragraph (d) will continue to be the responsibility and liability of the Contractholder. An Administration Charge will be made to take into account the benefit payment activity taking place after the date of discontinuance of this Agreement.

## Section IX: Examination of Records

The Contractholder shall have the right to examine any records of The Travelers relating to benefit payments and requests for benefit payments under the Plan and the issuing of drafts for payment of benefits under the Plan; provided, however, that any examination of individual benefit payment records shall be carried out in a manner agreed to between the Contractholder and The Travelers designed to protect the confidentiality of the individual's medical information.

## Section X: Assignment

No assignment by either party pertaining to this Agreement shall be valid without the consent of the other party.

## Section XI: Applicable Law

This Agreement shall be governed by the Laws of the State of Connecticut.

## Section XII: Amendments

**This Agreement may be amended as mutually agreed to in writing by the parties at any time.**

## Section XIII: Execution of Agreement

**IN WITNESS WHEREOF, the Contractholder and The Travelers have caused this Agreement to be executed in duplicate by their respective officers duly authorized so to do.**

| | |
|---|---|
| THE TRAVELERS INSURANCE COMPANY | CAP STAFFING, INC. |
| By______________________________ | By______________________________ |
| Dated at________________________ | Dated at________________________ |
| This______day of_________,1989 | This______day of__________,1989 |

# EXHIBIT A

TO

ADMINISTRATIVE SERVICES AGREEMENT

BETWEEN

CAP STAFFING, INC.

AND

THE TRAVELERS INSURANCE COMPANY

Employees Eligible and Plan Benefit Descriptions:

> The Plan Benefit Descriptions are the Health Benefits described in the Cap Staffing, Inc. Summary Plan Descriptions for all Eligible Employees.

## EXHIBIT B

TO

ADMINISTRATIVE SERVICES AGREEMENT

BETWEEN

CAP STAFFING, INC.

AND

THE TRAVELERS INSURANCE COMPANY

## ADMINISTRATIVE SERVICES OF THE TRAVELERS

1. Benefit Entitlement Determination

   (a) During the continuance of this Agreement, all requests for benefit payments under the Plan shall be made to The Travelers on forms satisfactory to The Travelers. The Travelers will determine the entitlement to Plan Benefits as to any request for benefits in accordance with the Plan and The Travelers benefit cost control standards and procedures and practices applicable to benefits under the Plan.

   (b) The Contractholder and The Travelers shall agree upon procedures through which the eligibility of an employee or dependent for benefits under the Plan shall be determined.

   (c) With respect to any person who makes a request for Plan benefits which is denied, The Travelers will notify said person of the denial and of his right of review of the denial, in a manner agreed to between the Contractholder and The Travelers designed to satisfy the requirements of the Employee Retirement Income Security Act of 1974 (P.L. 93-406).

2. Benefit Payments

   Whenever The Travelers determines that benefits are payable under the Plan, The Travelers shall issue a draft in payment of such benefits which, subject to acceptance by The Travelers, and subject to the terms and conditions of this Agreement, shall be paid from the Contractholder's bank account, as set forth in Section V.

3. Plan Benefit Development

   The Travelers shall provide services in connection with the design and development of the Plan, both initially and in connection with revisions to the Plan, including

(a) underwriting and actuarial services, including estimates of Plan costs and costs of potential Plan revisions.

(b) Preparation of Plan benefit description.

4. Plan Benefit Booklets

Subject to the Contractholder's review and concurrence, The Travelers shall prepare benefit booklets for distribution to covered employees. The Contractholder and The Travelers will include in the Plan booklet the necessary Plan Description information as may be required under the Employee Retirement Income Security Act of 1974 (P.L. 93-406).

5. General Administration

The Travelers Group Field and Home Office personnel will be available to assist the Contractholder in connection with the general administration of the Plan, including assistance as to the enrollment of eligible persons under the Plan and administration and record keeping systems for the ongoing operation of the Plan.

6. Privilege of Obtaining an Individual Policy of Insurance Under Certain Conditions

During the continuance of this Agreement, The Travelers will make individual policies of insurance available subject to the conditions of Exhibit B-1.

7. The Travelers shall maintain all benefit payment records as to requests for benefits for a period of four years following the month in which final benefit payment was made as to a benefit file. In the event of discontinuance of this Agreement, any such records in possession of The Travelers shall be forwarded to the Contractholder as soon as there is no further need in connection with the services performed by The Travelers.

8. Plan Reports

The Travelers shall prepare the following reports as to the Plan:

(a) The Travelers shall make the necessary reporting to the United States Internal Revenue Service as to payments made to physicians and other medical care providers.

(b) The Travelers shall provide the Contractholder with reports as to information available to The Travelers and required to be provided annually as to the Plan, in accordance with the Employee Retirement Income Security Act of 1974.

(c) Other reports as applicable to Contractholder.

## EXHIBIT B-1

## PRIVILEGE OF OBTAINING INDIVIDUAL INSURANCE

1. Subject to the limitations stated in paragraph 3, The Travelers agrees to provide to Employees and certain Dependents of Employees of the Contractholder, a privilege to obtain a policy of individual health insurance, without a showing of evidence of insurability, in the event that the Employee or Employee's Dependent ceases to be eligible for health benefits under the terms of the Plan due to the following events:

   (a) termination of Employee's employment in the classes eligible for health benefits,

   (b) death of the Employee while the Employee's Dependents are covered under the Plan,

   (c) with respect to a child of the Employee, due to such child ceasing to be a Dependent, as defined under the Plan, or due to termination of the Employee's employment in the classes eligible for such benefits provided such child has attained the age of nineteen, or

   (d) with respect to the Employee's wife or husband, due to the termination of his or her marriage to the Employee.

2. Subject to the limitations stated in paragraph 3, The Travelers agrees to provide to former Employees and certain Dependents of Employees or former Employees of the Contractholder, a privilege to obtain a policy of individual health insurance, without a showing of evidence of insurability, if the former Employee's or Dependent's coverage has been continued pursuant to Title X of Public Law 99-272, at the end of the period of continuance, to the extent required by said law.

3. In order to obtain the policy of individual health insurance the Employee and/or the Employee's Dependents must make application to The Travelers and pay the initial premium for said policy within Thirty-one (31) days after the termination of coverage under the Plan. However, The Travelers shall be under no obligation to provide a policy of individual health insurance in the event that the Employee or Dependent becomes eligible under the Plan during such Thirty-one day period. Other limitations which apply to the privilege provided in paragraph 1 and 2 are as follows:

   (a) The individual policy shall not cover the Dependents of the Employee unless the Dependents were covered under the Plan at the time of the termination of the Employee's eligibility under the Plan or the period of continuation described in paragraph 2.

   (b) No such individual policy shall be issued to a Retired Employee unless he or she ceases to be included within the term "Retired Employee" as defined under the Plan.

G003 (35)

(c) If the benefits applicable to any person under the Plan are less than the benefits provided under the individual policy of health insurance, issuance of such individual policy shall be subject to the underwriting rules of The Travelers for the issue of individual policies.

(d) If any other coverage (group or otherwise) for hospital expenses or service is in force or has been requested or applied for with respect to any person for whom coverage under such individual policy is requested, The Travelers may (a) decline to issue such individual policy if such other coverage was not in force prior to the termination of the Employee's benefits under the Plan, or (b) limit the benefits under such individual policy if such other coverage was in force prior to the termination of the Employee's benefits under the Plan.

4. The form of any individual policy issued pursuant to this provision, the coverage thereunder, and all other terms and conditions thereof shall be provided by the rules of The Travelers for such individual policy at the time of such application. The effective date of an individual insurance policy issued pursuant to the foregoing provisions shall be the date of termination of coverage under the Plan.

5. In event of the death of an Employee whose Dependents were covered under the Plan, during the Thirty-one day period allowed hereunder for making application for an individual policy and before any such individual policy shall have become effective, the Employee's Dependents shall have the privilege of obtaining an individual policy on the basis and subject to the conditions herein before indicated.

## EXHIBIT C

TO

ADMINISTRATIVE SERVICES AGREEMENT

BETWEEN

CAP STAFFING, INC.

AND

THE TRAVELERS INSURANCE COMPANY

## DUTIES OF THE CONTRACTHOLDER

1. The Contractholder shall provide The Travelers on a timely basis with such information as to the employees and dependents covered under the Plan as will be necessary for The Travelers to determine eligibility as to requests for Plan benefits, and to provide Plan cost estimates and reports as set forth in Exhibit A.

2. The Contractholder shall provide The Travelers with such information as to the Plan benefits as will enable The Travelers to determine benefits payable under the Plan and to prepare the Plan benefit booklet for distribution to employees. The Travelers and the Contractholder shall endeavor to complete preparation of the Plan benefit booklet so that such booklet may be distributed prior to the effective date of the Plan. If the Plan benefit booklet is not distributed prior to such date, the Contractholder shall deliver to each employee prior to such effective date written notification that as of the effective date of the Plan it has assumed liability for payment of Plan benefits and that Plan benefit payments will be administered by The Travelers.

# EXHIBIT D
TO
ADMINISTRATIVE SERVICES AGREEMENT
BETWEEN
CAP STAFFING, INC.
AND
THE TRAVELERS INSURANCE COMPANY

## SCHEDULE OF CHARGES

(a) Subject to the following Paragraphs, the Administrative Service Charge for each month of this Agreement shall be the sum of 9.49% of the dollar amount of the drafts be issued by The Travelers pursuant to this Agreement.

(b) The Travelers shall send a statement to the Contractholder each month. The statement will include an estimate of the Administrative Service Charge for such month, determined in accordance with the preceding paragraph, and any outstanding adjustment made to the charges for any preceding month after determining the actual charge for such month.

(c) An additional administrative charge will also be made to the Administrative Service Charge for any month there is an amendment to the Plan or a change in the services to be performed by The Travelers, to cover costs incurred by The Travelers in connection with implementing such amendment or change.

(d) A final accounting will be made for the Administrative Service Charges attributed to fees and expenses incurred during an Agreement Period. The Travelers will notify the Contractholder of the adjustment within four months of the end of the Agreement Period. The final Administrative Service Charge for the Agreement Period will include any and all adjustments for
  (i) interest on late or overpayments made to the bank account,
  (ii) interest on late or overpayments for fees,
  (iii) Add on charges for non-recurring expenses incurred during the Agreement Period.

Any amount payable to the Contractholder or The Travelers in accordance with the preceding paragraph shall be reflected in the following month's statement.

[illegible] (38)

Senate Permanent Subcommittee
on Investigations

EXHIBIT # 26

PROVIDED BY PENSION & WELFARE
BENEFITS ADMINISTRATION

CLOSED MEWA CASES

From 1987 through the current time, PWBA closed the following MEWA cases:

A. Closed by Litigation

1. Cascade Employers Association/Pacific N.W. Employers Insurance Trust - San Francisco Area Office, Case No. 71-6502(48)

   Consent Judgment and Order against Cascade Employers Association (CEA) was obtained on April 4, 1988. CEA made repayments to the subject MEWA totalling $937,338.

B. Closed by Voluntary Compliance or Without Finding Any Violations

1. The Atlanta Area Office closed ten (10) MEWA cases without finding any ERISA violations. Five of these cases were limited reviews and the remainder were full-scale investigations. The Atlanta AO also conducted investigations of seven different MEWAS which were closed without finding any violations during the year 1985.

2. The Cincinnati Area Office closed six MEWA cases, three of which were closed through obtaining voluntary compliance settlements. The other three cases were closed without finding any ERISA violations. Five of the six MEWA cases were full-scale investigations with the other case being a limited review. Cincinnati AO also has conducted a major investigation of a MEWA known as the Cleveland Builders Exchange which is currently being litigated in U.S. District Court.

3. The Dallas Area Office closed ten MEWA cases, eight of which were closed without finding any violations. One case was closed through obtaining voluntary compliance. One case was found to involve possible criminal violations and was referred, in 1987, to the FBI and the Louisiana Department of Insurance. Six of the above cases were full-scale investigations, and the remainder were limited reviews.

4. The Kansas City Area Office conducted one MEWA investigation which found certain ERISA violations. However, the case was closed without any action as the losses were made up by contributing employers, and the MEWAS' benefits were fully insured.

5. The San Francisco Area Office closed one MEWA investigation without finding any ERISA violations.

## OPEN MEWA CASES

PWBA has approximately thirty one (31) open investigations on MEWAs at the current time. PWBA's open investigations on MEWAs have the following characteristics:

- Every one of PWBA's ten Area Offices has at least one open full-scale MEWA investigation.

- PWBA is currently conducting six criminal MEWA investigations.

- Regarding the age of PWBA's MEWA cases, one was open in September 1985. This investigation (Cleveland Builders Exchange) is currently being litigated in U.S. District Court. With one other exception, every other open MEWA investigation has been opened subsequent to September 1988. Nine of the open cases were opened within this calendar year.

- Regarding the source of these cases, seven were opened pursuant to participant complaints, nine were opened based upon leads from sources other than a participant, i.e., a newspaper, etc; three were referrals from state agencies; and the remainder were opened based upon either targeting programs or as a result of knowledge obtained in ongoing civil investigations.

- Many of the MEWA investigations are being coordinated with state agencies and/or the Office of Inspector General/OLR and the FBI.

**U.S. Department of Labor**
Pension and Welfare Benefits Administration
Washington, D.C. 20210

Senate Permanent Subcommittee
on Investigations

EXHIBIT # 27

RECEIVED
APR 19 1990
ADM

APR 11 1990

Mr. L. J. Darter, III
Georgia Insurance Commission
Seventh Floor, West Tower
Floyd Building
2 Martin Luther King, Jr., Drive
Atlanta, Georgia 30334

Dear Mr. Dartor:

This responds to your letter of March 4, 1990, regarding the National Business Association Trust ("NBAT").

Your letter follows upon Opinion 89-33A (issued to you December 12, 1989) in which the Department of Labor ("the Department") concluded that NBAT was a "multiple employer welfare arrangement" ("MEWA") within the meaning of section 3(40) of title I of the Employee Retirement Income Security Act of 1974 ("ERISA"). Specifically, you raise the matter that, as stated in the opinion letter, the Department determined it was not necessary at that time to render an opinion as to whether NBAT was an "employee welfare benefit plan" within the meaning of section 3(1) of title I of ERISA. You explain that a cease and desist order issued by the Commissioner of Insurance of the State of Georgia ("the Commissioner") has been in force against NBAT and that the Commissioner's Office currently is seeking to determine responsibility under the Georgia Insurance Code for any unpaid claims of NBAT and premium taxes. You indicate that such responsibility depends on whether NBAT was subject to the state law requirement to have a certificate of authority to transact insurance in Georgia. You believe that question may require an opinion by the Department as to whether NBAT was an employee welfare benefit plan within the meaning of section 3(1) of ERISA. We disagree as explained below.

Section 514(b)(6) of ERISA provides an exception to preemption under ERISA section 514(a) for any employee welfare benefit plan (as defined by section 3(1) of ERISA) that is a MEWA. In general, the exception permits application of state insurance law to a MEWA as follows: If the MEWA is "fully insured" within the meaning of section 514(b)(6)(D) of ERISA, state insurance law may apply to the extent it provides standards requiring the maintenance of specified levels of reserves and contributions, and provisions to enforce such standards. If the MEWA is not fully insured, state insurance law may apply to the extent not inconsistent with title I of ERISA. Thus, for example, state laws requiring a certificate of authority to transact insurance generally would not be preempted with respect to an ERISA-covered employee welfare benefit plan that is a MEWA and is not fully insured.

We note that the Commissioner has taken the position that NBAT was not fully insured within the meaning of ERISA section 514(b)(6)(D). (See item 12 under "Findings of Fact" in the Cease and Desist Order dated October 24, 1989.) It follows from that position that, even if NBAT were an employee welfare benefit plan within the meaning of ERISA section 3(1), application of Georgia insurance law to NBAT generally has not been preempted under section 514 of ERISA. Therefore, it appears unnecessary to obtain an opinion from the Department on the status of NBAT under section 3(1) of ERISA in order for the Commissioner to determine whether the Georgia certificate of authority requirement applied to NBAT.

I hope you find this information to be helpful.

Sincerely,

Helene A. Benson

Helene A. Benson
Chief
Division of Coverage
Office of Regulations
 and Interpretations

1926 Quail Circle
Lugoff, S.C. 29078
May 8, 1990
(803) 438-6344

Senate Permanent Subcommittee
on Investigations

EXHIBIT # 28

Senator Sam Nunn
U.S. Senate P.S.I
S.R. 100
Washington, D.C. 20510

Dear Senator Nunn,

I'm writing to let you know what a mess I got into with an insurance company.

My husband Bobby had taken a second job for extra money; for a few weeks. He didn't take out the insurance because he had insurance on his other job. It turned out that on the second job he made more money and it was a much safer job so he took it and quit the first job. That left me and my three children without insurance. We then went to an insurance company and took out a health policy; till we could get something better.

I decided to go find me a job to get better insurance. There was a new Taco Bell fixing to open up so I went there and ask them if they had insurance for the employees; They said yes it was good insurance. I went to work for them. They brought in an insurance representative, his name is Dick Browney. I took out health, dental and life insurance $42 something every two weeks.

Life insurance: 10,000 on myself
5,000 on my husband
2,000 each on my children

The insurance company was Travelers. Sometime around July or August Dick Browney called another insurance meeting to let us know that Travelers had dropped us but, he had another insurance company that was gona take over with exactly the same benefits. We had to sign new forms. I'm told the insurance was Cap Staffing. Although when I sent my claims in they were to National Benefit Consultant. I'm sending you a copy of my card and some things.

August 22, 1989 was my first Doctor's appointment; they did some test on me. When the results came back they were bad, so I had to go back for more test. When the second test came back they showed I had Cervix Cancer, I was then told I would have to have a Cone Biopsy as an out patient to see how advance the cancer was, then have a hysterectomy.

Doctor Beacon was ready to have her baby; so her associate Dr. Shiply did my Cone Biopsy. When I went back for my check up after my Cone Biopsy, Dr. Shiply told me that I didn't need to wait to have my hysterectomy because the cancer was on the surface ready to spread.

A few days after that we had another insurance meeting at work. Dick Browney told us that our insurance was canceled as of that day. I told him I was in the middle of a claim; he said he knew that, he told me to go call the insurance company and explain that to them. They were very rude and told me it was canceled.

Because I had no insurance the nurse at Dr. Beacon's office told me I'd have to get some financial help before they'd schedule my surgery. They sent me to a social worker, but she said we made to much money.

We went through pure hell for nearly four months trying to figure out a way to get my surgery done. Not knowing if the waiting was killing me.

In November or December the insurance company made a partial payment; it was somewhere around $120.00 I'm not sure.

Someone told me to go to the insurance commission. I went there and gave them all my information. They investigated and told me that my insurance people weren't really insurance people and I needed to get a lawyer. Because of this I'm under a lot of pressure at work. Fred Kotoske the man that ownes the Taco Bells tells me I don't need a lawyer; that his lawyers are suing them. He's real careful not to say things to hurt him, but he tells me things in a round bought way trying to get me to do things his way. When it comes right down to it I probably won't have a job. I know they can't fire me over this but they've got ways. I watched them fire our manager because he hurt his back and was turning it in on workmens comp they make up things.

We'd done everything we could think of, my husband went to several insurance companies trying to get insurance on me. They told him they didn't know anyone that would insure me with pre-diagnosed cancer. Then he went job hunting; he went five different places. One of them said their insurance would cover me so he took an unsafe job so I could have my surgery. The insurance cost $44.00 a week and was $300.00 deductible. I didn't trust them so I checked with them myself. They told me because I had been pre-diagnosed they would just pay $5,000.00 on my surgery.

I thought my troubles was over they scheduled my surgery. About a week before I was to go in the hospital, the people at the hospital started calling me wanting to know who was gona pay the rest of my bill. I tried to explain to them that I was trying to sue the insurance company for the money. Every day they were calling me at work telling me I had to get my employer to say he'd pay the rest of my bill or I'd have to pay the difference before I went in the hospital. My lawyer Jim Gorbett called them and must have straightened them out. I went in and had my surgery; scared to death, I didn't know what to expect next.

There's still a lot of things uncertain. I know some people who has had the same thing I've got and it came right back on them.

I'm sitting here worrying all the time about the hospital and doctor bills; afraid it might ruin our credit that we worked hard to get.

I hope these people are caught and put away for life. I'm just one of many they've done like this. I can't began to tell you the stress and pain my family has went through because of this.

Yours Truly,

Carolyn Sharpe

**National Benefit Consultants, Inc.**

EMPLOYER
UNIVERSAL STAFFING - ASSOC

|  |  |  |
|---|---|---|
| INSURED NUMBER |  | GROUP NUMBER |
| 408-08-3424 |  | 87802ASC |
| INSURED NAME |  |  |
| SHARPE, CARCLYN |  |  |
| BENEFIT | COVERAGE | EFFECTIVE DATE |
| M/D | FAMILY | 08/01/89 |

TO HOSPITAL OR PHYSICIAN: At the time this card was issued
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nun

**IMPORTANT:** For any non-emergency inpatient hospital admission precertification is required within the time specified in the insureds insurance plan. **CareReview** must be notified within 72 hours for emergency inpatient admissions. **YOUR CLAIM WILL BE AFFECTED.**
Call 1-(800) 236-2515 1-(800) 334-7504 NATIONWIDE

BILLING INSTRUCTIONS Forward your itemized bill directly to the Administration Office listed below

NBC INC

**National Benefit Consultants, Inc.**
P.O. Box 19035 • Green Bay, WI 54307-9035
414-496-2500 • Toll Free (WI) 1 800 236-2515
Toll Free (Nationwide) 1 800 334-7504

RICHARD F. CELESTE
Governor

(614) 644-2651

STATE OF OHIO
**DEPARTMENT OF INSURANCE**
2100 STELLA COURT
COLUMBUS 43266-0566

Senate Permanent Subcommittee
on Investigations
EXHIBIT # 29

VIA FEDERAL EXPRESS

May 14, 1990

The Honorable Sam Nunn, Chairman
Permanent Subcommittee
on Investigations
United States Senate
100 Russell Senate Building
Washington, D.C. 20510

Dear Senator Nunn:

Thank you for your letter of May 8, 1990, inviting the Ohio Department of Insurance to submit a written statement to be part of the record of the May 15, 1990, hearing regarding ERISA and MEWAs.

Ohio is Vice-Chair of the NAIC's ERISA Working Group, which is developing materials to assist states in identifying and taking enforcement action against entities (including MEWAs) offering health care illegally.

Many of our concerns about MEWAs are described in the prepared testimony of Commissioner Jim Long of North Carolina.

We appreciate the opportunity, however, to emphasize several changes that need to be made to ERISA to allow for more effective enforcement of matters left to the states.

Although changes to the entire structure of ERISA are being studied, we have limited our comments to changes that should be made assuming the underlying structure stays the same.

1. ERISA should require plans offering health care to identify themselves to State Insurance Departments and properly categorize themselves as (i) single employer plans, (ii) Taft-Hartley Labor Union Trusts, (iii) "fully insured" MEWAs, or (iv) "not fully insured" MEWAs.

2. ERISA should make clearer the statutory language dividing jurisdictional responsibility between the states and the federal government. The current language is complex and allows plans to cloud the jurisdictional issues.

3. ERISA should describe more clearly the difference(s) between MEWAs that are "fully insured" and those that are "not fully insured."

4. ERISA currently provides that states may regulate "not fully insured" MEWAs if the regulation is "not inconsistent with ERISA." ERISA should be amended (or supplemented by regulations) to further clarify what is meant by the phrase "not inconsistent with ERISA."

Thank you for the opportunity to comment. If you or your staff have questions, please do not hesitate to call.

Sincerely,

George Fabe
Director

GF:NKR:wkm

cc: Commissioner Jim Long
Kevin Cronin, NAIC

nkr/samnunn/txtneil

**U.S. Department of Labor**

Pension and Welfare Benefits Administration
Washington, D.C. 20210

Senate Permanent Subcommittee
on Investigations

EXHIBIT # 30

JUN 21 1990

The Honorable Sam Nunn
Chairman
Permanent Subcommittee on Investigations
Committee on Governmental Affairs
United States Senate
Washington, D.C. 20510-6250

Dear Mr. Chairman:

Enclosed are our responses to questions raised at the May 15, 1990 hearing of the Permanent Subcommittee on Investigations entitled "Fraud and Abuse in Employer Sponsored Health Benefit Plans." The questions you raised relate to the Pension and Welfare Benefits Administration's (PWBA) enforcement activities with respect to Multiple Employer Welfare Arrangements (MEWAs), our criminal enforcement program, and the Department's response to the President's Commission on Organized Crime. In accordance with your request, we have also enclosed copies of correspondence between PWBA and the State of Georgia with respect to Georgia's request for an advisory opinion concerning the National Business Association of Trusts.

We welcome the opportunity to provide the requested information and hope that our responses will assist you and the Subcommittee. If we can provide any further information to you, please do not hesitate to contact my office.

Sincerely,

David George Ball
David George Ball
Assistant Secretary

Enclosures

The following is a restatement of your questions and our responses:

Question: Provide an update on PWBA's activities with respect to MEWAs.

Answer:

On March 29, 1990, I delivered a speech on the problem of MEWAs to the Second National Conference on Insurance Fraud, sponsored by the Law Enforcement Coordinating Committee, in Atlanta Georgia. The Conference was attended by over 100 representatives from 26 states and included officials from state insurance departments, representatives from state attorney general's offices, local U.S Attorneys, as well as representatives from the Pension and Welfare Benefits Administration (PWBA) and the Department of Labor's Office of Inspector General.

At the Conference, I personally met and answered questions from attendees from various states and discussed the coordination of PWBA's and state enforcement efforts. In addition, I was able to obtain comments from attendees concerning the Department's six point program for assisting the states with respect to MEWAs.

I was accompanied at the Conference by other PWBA officials. PWBA officials in attendance from the National Office included Charles Lerner, the Director of Enforcement for PWBA, David Stander, the Office of Enforcement's National Coordinator of MEWA Enforcement, and John Keene, a Senior Employee Benefit Plan Specialist in PWBA's Office of Regulations and Interpretations, who attended Conference seminars and were available to answer questions from the attendees concerning specific cases.

In addition, Shannon Davis, the Deputy Area Director of the Atlanta Office, three Atlanta Office investigators and Robert Surrette of the Boston Area Office attended the Conference. I believe the presence of Area Office personnel was particularly helpful to Conference attendees. For example, as my March 15 testimony indicated, the Boston Office is currently investigating a MEWA and its successor MEWA which is insolvent. I testified that the Boston Area office wrote to 33 different state insurance Departments in order to share information with respect to this MEWA. On May 24, 1990 the Boston Area Office distributed additional information to 39 State insurance commissioners with respect to this MEWA. To date, the States of Massachusetts, Georgia, and North Carolina have taken enforcement actions against the MEWA.

I am also pleased to report that progress has been made concerning the dissemination of PWBA's advisory opinions relating to MEWAs. As you may recall, one of Secretary Dole's six points to assist the states with MEWA enforcement was the quarterly distribution of advisory opinions to the states to enhance the information exchange with respect to these arrangements. At the conference, we were informed that the National Association of Insurance Commissioners (NAIC) maintains an on-line information service which provides information to the states with respect to insurers who are subject to cease and desist orders. An arrangement was agreed to whereby PWBA will provide the NAIC with information on the issuance of advisory opinions dealing with MEWAs for dissemination through the information service.

I am pleased to report on the progress PWBA is making with respect to the coordination of enforcement efforts and the exchange of information with the states. I will keep you informed as our progress develops.

Question: Provide details on the State of Georgia's request for an advisory opinion in determining whether National Business Association of Trusts (NBAT) was an ERISA plan under the definition in ERISA.

Answer:

During the hearing you raised questions concerning the Department's handling of certain requests from the Georgia Insurance Commission relating to the National Business Association Insurance Trust (NBAT). Specifically, you inquired as to whether the Department has a policy of not furnishing expert witnesses for state proceedings and whether the Department has a policy of not issuing rulings as to whether a multiple employer welfare arrangement (MEWA) is an employee benefit plan for purposes of Title I of ERISA. We indicated that we would review the facts relating to the Georgia Insurance Commission's requests and apprise you of our findings. Our understanding of the facts is as follows.

On November 1, 1989, Mr. L. J. Darter, III, of the Georgia Insurance Commission, requested an advisory opinion as to whether the NBAT is an employee welfare benefit plan covered by Title I of ERISA and whether the NBAT is a MEWA within the meaning of ERISA section 3(40) of Title I. On November 3, 1989, Mr. Darter made an oral request for a witness to appear at a hearing in Atlanta concerning the status of the NBAT. This request was followed by a written request, dated November 7, 1989. It was explained to Mr. Darter that, given the limited personnel resources of the PWBA, it would be very difficult to accommodate every request for a Departmental representative to appear at a state proceeding. It was further explained that an advisory opinion, which is an official ruling of the Department, addressing the status of the NBAT as a MEWA and the states ability to regulate that MEWA would appear to serve the same purpose as an expert witness. An advisory opinion finding the NBAT to be a MEWA and, therefore, subject to state regulation, was issued to Mr. Darter on December 12, 1989 (Opinion No. 89-33A).

On or about January 11, 1990, Robert J. Doyle, Director of PWBA's Office of Regulations and Interpretations, received a subpoena from the Georgia Insurance Commissioner's Office to appear at a hearing concerning the NBAT. Mr. Darter explained that, while the advisory opinion letter was what the State needed, a representative of the Department may, for procedural reasons, be required to appear to establish a foundation for admitting the letter into evidence at the hearing. After discussing the matter further with Mr. Darter, it was agreed that Mr. Doyle would furnish an affidavit, which would be used to introduce the opinion and, if the affidavit was unacceptable, PWBA's Area Director for Atlanta would be authorized to testify for the Department. We understand that the affidavit, without the personal appearance of a witness, was sufficient and that the State was successful in its effort to enjoin the NBAT.

By letter dated March 4, 1990, Mr. Darter requested that the Department issue a determination as to whether the NBAT was an "employee welfare benefit plan" subject to Title I of ERISA. The only issue raised by Mr. Darter's March 4 request related to whether the NBAT is exempted from the requirement to obtain a certificate of authority to transact insurance in Georgia by virtue of its status under ERISA. Inasmuch as a state's ability to subject MEWAs to state insurance regulation is not contingent upon whether or not a MEWA is an "employee welfare benefit plan" for purposes of Title I of ERISA (i.e., the MEWA exception to ERISA preemption applies to MEWAs which are employee welfare benefit plans), we did not believe it was necessary to determine the status of the NBAT in order to be responsive to Mr. Darter's request. In our April 11, 1990 response to Mr. Darter, we indicated that state laws requiring a certificate of authority to transact insurance generally would not be preempted with respect to an ERISA-covered employee welfare benefit plan that is a MEWA and is not fully insured. We also noted that, in view of the factual determination by the Georgia Insurance Commissioner that the NBAT is not fully insured, even if NBAT were determined to be an employee welfare benefit plan, application of Georgia Insurance law would not be preempted under ERISA section 514.

We believe that PWBA has been responsive to each of the Georgia Insurance Commission's requests for assistance. We also wish to assure you that we will continue to provide each of the states with the necessary technical and enforcement assistance required in the MEWA area.

OFFICE OF
COMMISSIONER OF INSURANCE

**WARREN D. EVANS**
COMMISSIONER OF INSURANCE
SAFETY FIRE COMMISSIONER
INDUSTRIAL LOAN COMMISSIONER
COMPTROLLER GENERAL

SEVENTH FLOOR WEST TOWER
FLOYD BUILDING
2 MARTIN LUTHER KING JR. DRIVE
ATLANTA, GEORGIA 30334

November 1, 1989

Mr. John Keene
Employee Benefit Plans Specialist
United States Department of Labor
Pension and Welfare Benefits Administration
Room N-5646
200 Constitution Avenue, NW
Washington, DC 20210

[illegible] - 1989
P-10#13A

RE: Request for Department of Labor Opinion - National Business Association Trust

Dear Mr. Keene:

On October 24, 1989, the Honorable Warren D. Evans, Commissioner of Insurance of the State of Georgia, issued a Cease and Desist Order against National Business Association Trust ("NBAT"). NBAT represents that it is an employee welfare multiple employer welfare arrangement operating pursuant to the Employee Retirement Income Security Act of 1974, as amended, 29 U.S.C. § 1001 et seq. ("ERISA"). NBAT is administered by National Benefit Administrators, Incorporated, and local marketing in Georgia is done by Group Concepts.

I hereby request a Department of Labor opinion as to whether or not NBAT is an employee welfare benefit plan under ERISA, and whether or not it is a multiple employer welfare arrangement under ERISA. I am enclosing copies of the following documents:

1. Cease and Desist Orders
2. Trust Agreements
3. Plan Document and Summary Plan Description
4. Schedule of Benefits
5. List of Georgia groups (as furnished by Group Concepts)

If you need any additional information or documentation in this matter, please do not hesitate to call me at (404) 656-2060. We anticipate that NBAT will request an administrative hearing in this matter, and may file for a declaratory judgment in federal court. Therefore, we request that you expedite your response. Thank you for your assistance.

Sincerely,

L. J. Darter, III
Enforcement Officer

LJD:aa

1776

OFFICE OF
COMMISSIONER OF INSURANCE

**WARREN D. EVANS**
COMMISSIONER OF INSURANCE
SAFETY FIRE COMMISSIONER
INDUSTRIAL LOAN COMMISSIONER
COMPTROLLER GENERAL

SEVENTH FLOOR WEST TOWER
FLOYD BUILDING
2 MARTIN LUTHER KING JR DRIVE
ATLANTA GEORGIA 30334

November 7, 1989

Mr. John Keene
United States Department of Labor
Division of Coverage
ORI-PWBA
200 Constitution Avenue, NW
Washington, D.C. 20210

RE: Request for Witness - National Business Association Trust

Dear Mr. Keene:

This is in reference to our telephone conversation of November 3, 1989.

On November 1, 1989, this office sent you a request for a Department of Labor Opinion relative to National Business Association Trust ("NBAT"). Copies of relevant documents were attached to this request, including Cease and Desist Orders issued against NBAT. NBAT has requested a hearing on this matter, and a hearing has been scheduled for 10:00 A.M. on November 30, 1989. Copies of NBAT's request for hearing and the Notice of Hearing are attached.

Some of NBAT's contentions are as follows: The Commissioner of Insurance of the State of Georgia ("the Commissioner") does not have jurisdiction to regulate NBAT. Any authority of the Commissioner to regulate NBAT has been preempted under federal law, including but not limited to 29 U.S.C. § 1144. The exercise of any jurisdiction over NBAT by the Commissioner is a violation of the supremacy clause of the United States Constitution. The Commissioner is not empowered, authorized, or directed by statute to regulate an entity such as NBAT which provides benefits authorized under the Employee Retirement Income Security Act of 1974, as amended, 29 U.S.C. § 1001 et seq. ("ERISA").

We need a representative from the Department of Labor to appear as a witness at the hearing , in order to disprove NBAT's contentions. Specifically, we need a witness who can testify as to whether or not NBAT is an employee welfare benefit plan under ERISA, whether it is a multiple employer welfare arrangement under ERISA, and the extent, if any to which it is preempted from state regulation by ERISA. Please provide us with the name, address and telephone number of the representative who will appear as a witness. Also, please provide your written response to our request for a Department of Labor Opinion as soon as possible.

Thank you for your assistance in this important matter.

Sincerely,

L. J. Darter, III
Enforcement Officer

LJD:aa

cc to: Mr. Ray Maria
Acting Inspector General
U.S. Department of Labor
Room S-1303
200 Constitution Avenue, NW
Washington, D.C. 20210

ORIGINAL

IN THE OFFICE OF THE COMMISSIONER OF INSURANCE

STATE OF GEORGIA

IN THE MATTER OF:

CASE NO. 89C-21

NATIONAL BUSINESS ASSOCIATION TRUST;
NATIONAL BENEFIT ADMINISTRATORS, INCORPORATED;
and GROUP CONCEPTS.

## DEMAND FOR HEARING

Comes now NATIONAL BUSINESS ASSOCIATION TRUST (the "Trust") and hereby makes written demand for a hearing with respect to an October 24, 1989 Cease and Desist Order issued by the Commissioner of Insurance of the State of Georgia in this matter. National Business Association Trust is a person aggrieved by said Cease and Desist Order in that it may prohibit said Trust, its administrator, or agents of its administrator, from performing certain functions and taking certain actions which the Trust is obligated to perform and take under Trust documents. The said Cease and Desist Order also improperly and invalidly purports to subject the Trust to the jurisdiction of the Insurance Commissioner of the State of Georgia, and the Trust is exposed to the risk and expense of enforcement proceedings and other sanctions if it fails to comply with what the Trust believes to be an invalid order of the Insurance Commissioner. The Trust requests this hearing pursuant to O.C.G.A. § 33-2-17 showing as follows:

1.

The relief sought in this hearing includes a stay of the October 24, 1989 Cease and Desist Order; a clarification of said Cease and Desist Order to define, in terms which are not vague, ambiguous, and uncertain, the functions and acts which the Trust, its administrator, or any agents of its administrator are to cease and desist; a modification of the said Cease and Desist Order allowing the Trust, its administrator, and agents of its administrators to receive and retain contributions from existing Georgia employer participants in the Trust while refraining from soliciting or accepting any new Georgia employers as participants in the Trust plan, such modification to remain in effect while the Trust attempts to locate alternative benefit plans or coverage from other sources for the employees of the Trust's existing Georgia employer participants; and the entry of a new order revoking, voiding, and lifting the said Cease and Desist Order with respect to the Trust, its administrator and any agents of its administrator.

2.

The grounds relied upon as a basis for the above relief which is to be demanded at the hearing are set forth below:

(a) The Cease and Desist Order is so vague, ambiguous, and uncertain as to be unconstitutional and unenforceable.

(b) The Cease and Desist Order is unconstitutional as a denial of due process of law in that no hearing was afforded to the Trust, its administrator, or any agent of its administrator prior to the entry of the immediate Cease and Desist Order.

(c) The Insurance Commissioner of the State of Georgia does not have jurisdiction to regulate this Trust.

(d) Any authority of the Insurance Commissioner of the State of Georgia to regulate this Trust has been preempted under federal law, including but not limited to 29 U.S.C. 1144.

(e) The exercise of any jurisdiction over the Trust by the Insurance Commissioner of the State of Georgia is unconstitutional as a violation of the Supremacy Clause of the United States Constitution.

(f) The factual findings of the Insurance Commissioner of the State of Georgia concerning the Trust are inaccurate and not based on current evidence.

(g) The factual findings of the Insurance Commissioner of the State of Georgia concerning the financial solvency of the Trust are inaccurate and are not based upon current evidence.

(h) The conclusions of law set forth in the Cease and Desist Order are erroneous.

(i) The Insurance Commissioner of the State of Georgia is not empowered, authorized, or directed by statute to regulate an entity such as this Trust which provides benefits authorized under ERISA, 29 U.S.C. § 1001, *et seq*.

WHEREFORE, the National Business Association Trust gives notice to the Commissioner of Insurance of the State of Georgia and to National Benefit Administrators, Incorporated, and Group Concepts of this demand for a hearing by a person aggrieved by an order of the Insurance Commissioner of the State of Georgia, and the Trust hereby seeks the relief described above.

This 3rd day of November, 1989.

ROBERT D. McCALLUM, JR.
Georgia Bar No. 471550

ROBERT P. RIODAN
Georgia Bar No. 606431

Attorneys for National Business
Association Trust

OF COUNSEL:

ALSTON & BIRD
100 Galleria Parkway
Suite 1200
Atlanta, Georgia 30339-3195
404/881-7000

OFFICE OF COMMISSIONER OF INSURANCE

STATE OF GEORGIA

IN THE MATTER OF: )
)
NATIONAL BUSINESS ASSOCIATION )
TRUST; NATIONAL BENEFIT )
ADMINISTRATORS, INCORPORATED; )
AND GROUP CONCEPTS )

CASE NUMBER 89C-21

## NOTICE OF HEARING

On October 24, 1989, the Commissioner of Insurance of this State issued a Notice and Cease and Desist Order to National Business Association Trust; National Benefit Administrators, Incorporated; and Group Concepts. Said Notice and Order were amended on October 30, 1989. On November 3, 1989, the Georgia Insurance Department received a request for hearing from National Business Association Trust (hereinafter "Respondent") regarding said Cease and Desist Order.

WHEREFORE, Respondent is hereby required to be and appear before me or my duly authorized representative in the Hearing Room, 7th Floor, West Tower, Floyd Building, #2 Martin Luther King, Jr. Drive, Atlanta, Georgia, at 10:00 A.M. on November 30, 1989, and from time to time thereafter until this matter is finally concluded.

Respondent is further notified that the hearing will be held as indicated in the aforesaid Notices issued on

October 24, 1989 and October 30, 1989. Upon written request seasonably made by Respondent, a full record of the proceedings shall be transcribed and a copy furnished to the Commissioner at Respondent's expense, pursuant to § 32-2-21(e) of the Georgia Insurance Code.

HEREIN FAIL NOT. In the event of your absence at the duly appointed time and place stated herein, the Commissioner of Insurance will take such action as authorized by law.

Based upon full consideration of the evidence and testimony given at the hearing and the record transcribed therefrom, the Commissioner of Insurance will render a final decision in a timely manner.

This 6th day of November, 1989.

Warren D. Evans
WARREN D. EVANS
COMMISSIONER OF INSURANCE
STATE OF GEORGIA

**U.S. Department of Labor**

Pension and Welfare Benefits Administration
Washington, D.C. 20210

DEC 12 1989

89-33A

Mr. L. J. Darter, III
Georgia Insurance Commission
Seventh Floor, West Tower
Floyd Building
2 Martin Luther King, Jr., Drive
Atlanta, Georgia 30334

Dear Mr. Darter:

This is in reply to your request for an advisory opinion regarding the applicability of title I of the Employee Retirement Income Security Act of 1974 (ERISA). Specifically, you ask whether the National Business Association Trust (NBAT) is an employee welfare benefit plan within the meaning of section 3(1) of title I of ERISA and whether NBAT is a multiple employer welfare arrangement (MEWA) within the meaning of section 3(40) of that title.

You advise that NBAT was created pursuant to a trust agreement dated July 24, 1987, between the Coca-Cola Bottling Co. of S.E. Missouri and other unnamed corporations as the Company and Charles Sander as Trustee. The trust agreement states that it is an amendment of and successor to the Mid America Soft Drink Bottling Trust. The trust agreement states that the Company intends to adopt health care and welfare plans for the benefit of its employees and that it provides for the creation of a MEWA within the meaning of section 3(40) of title I of ERISA. The term "Company" is defined to include all employers which thereafter participate in NBAT. There are approximately 68 employers utilizing NBAT to provide medical coverage to their employees. In a telephone conversation with John Keene of this Office, you also stated that the employers utilizing NBAT to provide benefits to their employees do not constitute a controlled group and that NBAT is not maintained pursuant to any collectively bargained agreement.

Section 3(40)(A) of title I of ERISA defines the term "MEWA" to include:

> . . .an employee welfare benefit plan, or any other arrangement (other than an employee welfare benefit plan), which is established or maintained for the purpose of offering or providing any benefit described in paragraph (1) to the employees of two or more employers (including one or more self-employed individuals), or to their beneficiaries, except that such term does not include any such plan or other arrangement which is established or maintained--

> (i) under or pursuant to one or more agreements which the Secretary finds to be collective bargaining agreements, or
>
> (ii) by a rural electric cooperative.

Based upon the information you submitted, it is the position of the Department of Labor (the Department) that NBAT is a MEWA within the meaning of section 3(40). NBAT covers the employees of more than two separate, independent employers; is not maintained by a rural electric cooperative; and is not maintained under or pursuant to any collective bargaining agreement.

Although section 514(a) of ERISA provides that any state law or regulation which relates to an employee benefit plan covered by ERISA is preempted, P.L. 97-473 amended section 514(b) of title I of ERISA to provide:

> (6)(A) Notwithstanding any other provision of this section-- (i) in the case of an employee welfare benefit plan which is a multiple employer welfare arrangement and is fully insured (or which is a multiple employer welfare arrangement subject to an exemption under subparagraph (B)), any law of any State which regulates insurance may apply to such arrangement to the extent that such law provides--
>
> (I) standards, requiring the maintenance of specified levels of reserves and specified levels of contributions, which any such plan, or any trust established under such a plan, must meet in order to be considered under such law able to pay benefits in full when due, and
>
> (II) provisions to enforce such standards, and
>
> (ii) in the case of any other employee welfare benefit plan which is a multiple employer welfare arrangement, in addition to this title, any law of any State which regulates insurance may apply to the extent not inconsistent with the preceding sections of this title.
>
> (B) The Secretary may, under regulations which may be prescribed by the Secretary, exempt from subparagraph (A)(ii), individually or by class, multiple employer welfare arrangements which are not fully insured. Any such exemption may be granted with respect to any arrangement or class of arrangements only if such arrangement or each arrangement which is a member of such class meets the requirements of section 3(1) and section 4 necessary to be considered an employee welfare benefit plan to which this title applies.

Although section 514(b)(6)(B) provides that the Secretary of Labor may prescribe regulations under which the Department may exempt MEWAs from state regulation under section 514(b)(6)(A)(ii), the Department has previously stated that it did not see the need

to prescribe regulations under section 514(b)(6)(B) to exempt MEWAs from state regulation. The Department, at this time, has not changed its position. Accordingly, the Department is not providing MEWAs exemptions under section 514(b)(6)(B) from state regulation.

It is, therefore, the Department's position that NBAT is subject to state regulation at least to the extent provided in section 514(b)(6)(A), regardless of whether it is an employee benefit plan covered by title I of ERISA, because it is a MEWA within the meaning of section 3(40) of that title.

Because your request for an advisory opinion was concerned primarily with the issue of whether or not NBAT is subject to the applicable regulatory authority of the State of Georgia's insurance laws or is saved from such authority under the general preemption provision of section 514(a) of title I of ERISA, and because of the opinion above, we have determined it is not necessary at this time to render an opinion as to whether NBAT is an employee welfare benefit plan within the meaning of section 3(1) of that title.

The preceding constitutes an advisory opinion under ERISA Procedure 76-1. Accordingly, it is issued subject to the provisions of that procedure, including section 10 thereof relating to the effect of advisory opinions.

Sincerely,

Robert J. Doyle
Director of Regulations and Interpretations

OFFICE OF
COMMISSIONER OF INSURANCE

WARREN D. EVANS
COMMISSIONER OF INSURANCE
SAFETY FIRE COMMISSIONER
INDUSTRIAL LOAN COMMISSIONER
COMPTROLLER GENERAL

SEVENTH FLOOR, WEST TOWER
FLOYD BUILDING
2 MARTIN LUTHER KING, JR. DRIVE
ATLANTA, GEORGIA 30334

January 25, 1990

Mr. Sherwin Kaplan
Counsel for Fiduciary Litigation
United States Department of Labor
Office of Solicitor
200 Constitution Avenue, N.W.
Washington, D.C. 20210

RE: National Business Association Trust (NBAT), National Benefit Administrators, Incorporated (NBA), and Group Concepts

Dear Mr. Kaplan:

In reference to our recent telephone conversations, I am enclosing a format for an affidavit which could be used by Mr. Doyle to authenticate the Department of Labor advisory opinion, number 89-33A, dated December 12, 1989.

In order to have the advisory opinion admitted into evidence, it will be necessary for us to establish the authority of the officer who issued the document, the incumbency of the officer, and the genuineness of his signature. In this case, it will also be important to establish the Department of Labor procedure for issuing advisory opinions, and to specify the basis on which this opinion was issued.

Once I receive the executed affidavit, I will notify counsel for NBAT and NBA, Inc. of my intent to use it. If counsel does not object, we will attempt to use this affidavit to get the advisory opinion admitted into evidence.

If you have any questions, please do not hesitate to call me at (404) 656-2060. Thank you very much for your assistance.

Sincerely,

L. J. Darter, III
Enforcement Officer
Administrative Law Section

LJD:aa

Attachment

# AFFIDAVIT

CITY OF WASHINGTON )
DISTRICT OF COLUMBIA

Personally appeared ROBERT J. DOYLE before the undersigned officer duly authorized to administer oaths, who being first duly sworn, deposes and says that he resides at________________________________________________

____________________________________________________

__________________________________________________.

Affiant further states as follows:

Affiant makes this statement for use in a proceeding before the Insurance Commissioner the purpose of which is to determine whether National Business Association Trust, National Benefit Administrators, Incorporated and/or Group Concepts is in violation of the Insurance Code or Rules and Regulations adopted and promulgated thereunder.

________________________
(Robert J. Doyle)

Address: ________________________

________________________

Telephone No.: (   ) ____________________

CITY OF WASHINGTON
DISTRICT OF COLUMBIA

I, ____________________ (Name), a Notary Public in and for the City of Washington, District of Columbia, do hereby certify that Robert J. Doyle, personally known to me to be the same person whose name is subscribed to the foregoing instrument, appeared before me this day in person and acknowledged that he signed, sealed and delivered the said instrument as his free and voluntary act for the uses and purposes therein set forth.

Given under my Hand and Notarial Seal this ____ day of ________, 1990.

________________________
(NOTARY PUBLIC)

My Commission expires __________,
19__.

**U.S. Department of Labor**

Office of the Solicitor
Washington, D.C. 20210

February 13, 1990

Mr. L.J. Darter, III
Enforcement Officer
Administrative Law Section
Office of the Commissioner of Insurance
Seventh Floor, West Tower
Floyd Building
2 Martin Luther King, Jr. Drive
Atlanta, Georgia 30334

Re: NBAT, NBA and Group Concepts

Dear Mr. Darter:

Per your request, enclosed please find an affidavit by Robert J. Doyle, Director of the Office of Regulations and Interpretations, authenticating Department of Labor Advisory Opinion 89-33A. All of the language you requested be included in the affidavit has been included.

Also included, as Attachment II, is an officially authenticated copy of the Advisory Opinion itself. In Federal Court, a document authenticated as this one is, is considered to be admissible pursuant to Rule 902(1) of the Federal Rules of Evidence.

If there is anything else we can do to assist you in your pending administrative proceeding, please do not hesitate to ask.

Sincerely,

Sherwin Kaplan
Counsel for Fiduciary Litigation
Plan Benefits Security Division
Office of the Solicitor
200 Constitution Ave. NW
Room N-4611
Washington, D.C. 20210
(202)523-8623

## AFFIDAVIT

CITY OF WASHINGTON )
) ss.
DISTRICT OF COLUMBIA)

Personally appeared ROBERT J. DOYLE before the undersigned officer duly authorized to administer oaths, who being first duly sworn, deposes and says that his office address is the United States Department of Labor, Pension and Welfare Benefits Administration, 200 Constitution Ave. N.W., Room N-5671, Washington, D.C. 20210.

Affiant further states as follows:

1. Affiant is currently the Director of the Office of Regulations and Interpretations in the Pension and Welfare Benefits Administration of the United States Department of Labor, and has served in this position continuously since 1988.

2. With certain exceptions not relevant here, the Employee Retirement Income Security Act of 1974, as amended, 29 U.S.C. §1001 et seq. (ERISA) has conferred on the Secretary of the United States Department of Labor certain interpretive and enforcement authority with respect to Title I of that Act. Within the Department of Labor, this authority has been delegated to the Pension and Welfare Benefits Administration.

3. Included within this grant of authority is the authority to issue advisory opinions as to the application of ERISA and the regulations promulgated thereunder. The procedure for issuing such Advisory Opinions has been codified as ERISA Procedure 76-1 and published in 41 Fed. Reg. 36281 (August 27, 1976). A copy of this procedure is affixed to this affidavit as Attachment I.

4. Within the Pension and Welfare Benefits Administration, Affiant, by virtue of his office as Director of the Office of Regulations and Interpretations, has authority to sign Advisory Opinions on behalf of the Department.

5. Affixed to this affidavit as Attachment II is a true and correct copy of Advisory Opinion 89-33A. This Advisory Opinion was signed by Affiant personally in the course of his official duties and was prepared and executed in conformity with ERISA Procedure 76-1.

6. Advisory Opinion 89-33A is based on the representations made by the requestor as referenced in Advisory Opinion 39-33A and reflects the formal and official view of the United States

Department of Labor with respect to the matters discussed therein.

7, Affiant makes this statement for use in a proceeding before the Insurance Commissioner the purpose of which is to determine whether National Business Association Trust, National Benefit Administrators, Incorporated and/or Group Concepts is in violation of the Insurance Code or Rules and Regulations adopted and promulgated thereunder.

Robert J. Doyle

Business address: United States Department of Labor
Pension and Welfare Benefits
Administration
200 Constitution Ave. N.W.
Room N-5671
Washington, D.C. 20210

Business Phone: (202)523-7461

CITY OF WASHINGTON )
) ss.
DISTRICT OF COLUMBIA)

I, DIANA VERGAGNI, a Notary Public in and for the City of Washington, District of Columbia, do hereby certify that Robert J. Doyle, personally known to me to be the same person whose name is subscribed to the foregoing instrument, appeared before me this day in person and acknowledged that he signed, sealed and delivered the said instrument as his free and voluntary act for the uses and purposes therein set forth.

Given under my Hand and Notarial Seal this 13th day of February, 1990.

Diana Vergagni

My commission expires_________, 19__.

MY COMMISSION EXPIRES OCTOBER 14, 1990

*Applications received during the week ending Aug. 20, 1976*

| Name of applicant | Location of enterprise | Principal product or activity |
|---|---|---|
| Farm Fresh Meats, Inc. | Robertsdale, Ala. | Custom meat [illegible]. |
| Penn-Craft, Inc. | Perry, Fla. | Boat building and repairing. |
| [illegible] Corp. | [illegible], S.C. | Textile items. |
| [illegible] Grocery Co. [illegible] | [illegible] | Wholesale grocer. |
| [illegible] K. [illegible] | [illegible], S.C. | Leasing of textile warehouses. |
| Tri-County [illegible] Co., Inc. | [illegible], Tenn. | [illegible]. |
| [illegible] | [illegible], N.C. | [illegible]. |
| [illegible] Co. | [illegible], Okla. | Manufacturer of [illegible]. |
| [illegible] Co., Inc. | [illegible] | Manufacturer of [illegible] and [illegible]. |
| [illegible] Public Works Authority | [illegible], Okla. | Manufacturer of [illegible] yarn. |
| [illegible] Chemical Co. | [illegible], Calif. | Sales and [illegible] of [illegible] chemicals. |
| Tam Ply, Inc. | [illegible], Oreg. | Manufacturer of [illegible] and wood chips. |
| [illegible] Bros., Inc. | [illegible], Idaho | Sale of groceries. |
| [illegible] R. Freeman | [illegible], Idaho | Motel, restaurant, and grocery store. |
| G.I.V., Inc. | [illegible], Pa. | Manufacturer and sale of [illegible], and curtains. |

[FR Doc.76-25136 Filed 8-26-76;8:45 am]

## FEDERAL SUPPLEMENTAL BENEFITS (EMERGENCY UNEMPLOYMENT COMPENSATION)

### *Ending of Federal Supplemental Benefit Period in Montana*

This notice announces the ending of the Federal Supplemental Benefit Period in the State of Montana effective August 28, 1976.

BACKGROUND

The Emergency Unemployment Compensation Act of 1974 (Pub. L. 93-572, enacted December 31, 1974) (the Act) created a temporary program of supplementary unemployment benefits (referred to as Federal Supplemental Benefits) for unemployed individuals who have exhausted their rights to regular and extended benefits under State and Federal unemployment compensation laws. Federal Supplemental Benefits are payable during a Federal Supplemental Benefit Period in a State which has entered into an Agreement under the Act with the United States Secretary of Labor. A Federal Supplemental Benefit Period is triggered on in a State when unemployment in the State or in the State and the nation reaches the high levels set in the Act. During a Federal Supplemental Benefit Period the maximum amount of Federal Supplemental Benefits which are payable to eligible individuals is up to 13 weeks or 26 weeks, depending upon the level of the rate of insured unemployment in the State. A Federal Supplemental Benefit Period commenced in the State of Montana on January 26, 1975.

The Act also provides that a Federal Supplemental Benefit Period in a State will trigger off when the rate of insured unemployment in the State averages less than 5.0 percent over a period of thirteen consecutive calendar weeks. The benefit period actually terminates at the end of the third week after the week for which there is an "off" indicator, if the benefit period will have been in effect for a minimum duration of 26 weeks.

DETERMINATION OF "OFF" INDICATOR

The employment security agency of the State of Montana has determined under the Act and 20 CFR 616.19(b) (published in the FEDERAL REGISTER on March 22, 1976, at 41 PR 12151, 12157) that the average rate of insured unemployment in the State for the period consisting of the week ending on August 7, 1976, and the immediately preceding twelve weeks, was less than 5.0 percent.

Therefore, I have determined in accordance with the Act and 20 CFR 616.19(b), and as authorized by the Secretary of Labor's Order 4-75, dated April 16, 1975 (published in the FEDERAL REGISTER on April 28, 1975, at 40 FR 18515), that there was a Federal Supplemental Benefit "off" indicator in the State of Montana for the week ending on August 7, 1976, and that the Federal Supplemental Benefit Period in that State terminates on August 28, 1976.

INFORMATION FOR CLAIMANTS

Any individual to whom Federal Supplemental Benefits or Federal-State Extended Benefits were payable in the State (whether or not any payment actually was made), for any portion of the last week of the Federal Supplemental Benefit Period, will have an additional eligibility period beginning immediately following the end of the Federal Supplemental Benefit Period. During the additional eligibility period the individual will be entitled to Federal Supplemental Benefits to the same extent as if the Federal Supplemental Benefit Period continued to be in effect. The additional eligibility period will have a duration of 13 weeks, unless it is terminated sooner by reason of the beginning of a new Federal Supplemental Benefit Period in the State.

Individuals currently filing claims for Federal Supplemental Benefits will receive written notices from the Montana Division of Employment Security, Department of Labor, of the end of the Federal Supplemental Benefit Period in that State and its effect on their entitlement to Federal Supplemental Benefits. The notice to any individual who will have an additional eligibility period following the Federal Supplemental Benefit Period will include information concerning potential entitlement to Federal Supplemental Benefits during the additional eligibility period.

Although the Federal Supplemental Benefit Period has terminated, an Extended Benefit Period will continue in effect in the State due to the National "on" indicator for the Federal-State Extended Benefit Program, as announced in a notice published in the FEDERAL REGISTER on February 21, 1975, at 40 FR 7722. Therefore, Federal-State Extended Benefits will continue to be payable to eligible individuals in the State.

Persons who wish information about their rights to Federal Supplemental Benefits or Federal-State Extended Benefits in the State of Montana should contact the nearest Employment Service Office of the Montana Employment Security Division in their locality.

Signed at Washington, D.C., on August 23, 1976.

WILLIAM H. KOLBERG,
*Assistant Secretary for Employment and Training.*

[FR Doc.76-25065 Filed 8-26-76;8:45 am]

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## Office of Employee Benefits Security

## EMPLOYEE BENEFIT PLANS

### Advisory Opinion Procedure

It is the practice of the Department of Labor (the Department) to answer inquiries of individuals or organizations affected, directly or indirectly, by the Employee Retirement Income Security Act of 1974 (Pub. L. 93-406, hereinafter "the Act") as to their status under the Act and as to the effect of certain acts and transactions. The answers to such inquiries are categorized as "information letters" and "advisory opinions." This "ERISA Procedure" (ERISA Proc. 76-1) describes the general procedures of the Department in issuing information letters and advisory opinions under the Act, and is designed to promote efficient handling of inquiries and to facilitate prompt responses.

Section 7 of this procedure (instructions to individuals and organizations requesting advisory opinions relating to prohibited transactions and common definitions) is reserved. This section will set forth the procedures to be followed to obtain an advisory opinion relating to prohibited transactions and common definitions, such as whether a person is a party in interest and a disqualified person. In general, this section will incorporate a revenue procedure to be published by the Internal Revenue Service.

This advisory opinion procedure consists of rules of agency procedure and practice, and is therefore excepted under 5 U.S.C. 553(b)(3)(A) of the Administrative Procedure Act from the ordinary notice and comment provisions for agency rulemaking. Accordingly, the procedure is effective August 27, 1976.

SECTION 1. *Purpose.* The purpose of this ERISA Procedure is to describe the general procedures of the Department of Labor (the Department) in issuing information letters and advisory opinions to individuals and organizations under

ATTACHMENT I

the Employee Retirement Income Security Act of 1974 (Pub. L. 93-406), hereinafter referred to as "the Act". This ERISA Procedure also informs individuals and organizations, and their authorized representatives, where they may direct requests for information letters and advisory opinions, and outlines procedures to be followed in order to promote efficient handling of their inquiries.

SEC. 2. *General practice.* It is the practice of the Department to answer inquiries of individuals and organizations, whenever appropriate, and in the interest of sound administration of the Act, as to their status under the Act and as to the effects of their acts or transactions. One of the functions of the Department is to issue information letters and advisory opinions in such matters.

SEC. 3. *Definitions.* .01 An "information letter" is a written statement issued either by the Pension and Welfare Benefit Programs (Office of Employee Benefits Security), U.S. Department of Labor, Washington, D.C. or a Regional Office or an Area Office of the Labor-Management Services Administration, U.S. Department of Labor, that does no more than call attention to a well-established interpretation or principle of the Act, without applying it to a specific factual situation. An information letter may be issued to any individual or organization when the nature of the request from the individual or the organization suggests that it is seeking general information, or where the request does not meet all the requirements of section 6 or 7 of this procedure, and it is believed that such general information will assist the individual or organization.

.02 An "advisory opinion" is a written statement issued to an individual or organization, or to the authorized representative of such individual or organization, by the Administrator of Pension and Welfare Benefit Programs or his delegate, that interprets and applies the Act to a specific factual situation. Advisory opinions are issued only by the Administrator of Pension and Welfare Benefit Programs or his delegate.

.03 Individuals and organizations are those persons described in section 4 of this procedure.

SEC. 4. *Individuals and organizations who may request advisory opinions or information letters.* .01 Any individual or organization affected directly or indirectly by the Act may request an information letter or an advisory opinion from the Department.

.02 A request by or for an individual or organization must be signed by the individual or organization, or by the authorized representative of such individual or organization. See section 7.03 of this procedure.

SEC. 5. *Discretionary Authority to Render Advisory Opinions.* .01 The Department will issue advisory opinions involving the interpretation of the application of one or more sections of the Act, regulations promulgated under the Act, interpretive bulletins, or exemptions issued by the Department to a specific factual situation. Generally, advisory opinions will be issued by the Department only with respect to prospective transactions (i.e., a transaction which will be entered into). Moreover, there are certain areas where, because of the inherently factual nature of the problem involved, or because the subject of the request for opinion is under investigation for a violation of the Act, the Department ordinarily will not issue advisory opinions. Generally, an advisory opinion will not be issued on alternative courses of proposed transactions, or on hypothetical situations, or where all parties involved are not sufficiently identified and described, or where material facts or details of the transaction are omitted.

.02 The Department ordinarily will not issue advisory opinions relating to the following sections of the Act:

.02(a) Section 3(18), relating to whether certain consideration constitutes adequate consideration;

.02(b) Section 3(26), relating to whether the valuation of any asset is at current value;

.02(c) Section 3(27), relating to whether the valuation of any asset is at present value;

.02(d) Section 102(a)(1), relating to whether a summary plan description is written in a manner calculated to be understood by the average participant;

.02(e) Section 103(a)(3)(A), relating to whether the financial statements and schedules required to be included in the Annual Report are presented fairly in conformity with generally accepted accounting principles applied on a consistent basis;

.02(f) Section 103(b)(1), relating to whether a matter must be included in a financial statement in order to fully and fairly present the financial statement of the plan;

.02(g) Section 202 (other than section 202 (a)(3) and (b)(1)), relating to minimum participation standards;

.02(h) Section 203 (other than sections 203 (a)(3)(B), (b)(1) (flush language), (b)(2), (b)(3)(A));

.02(i) Section 204 of the Act (other than sections 204 (b)(1)(B), (b)(1)(A), (C), (D), (E)), relating to benefit accrual requirements;

.02(j) Section 205(e), relating to the period during which a participant may elect in writing not to receive a joint and survivor annuity;

.02(k) Section 208, relating to mergers and consolidation of plans or transfer of plan assets;

.02(l) Section 209(a)(1), relating to whether the report required by section 209(a)(1) is sufficient to inform the employee of his accrued benefits under the plan, etc.

.02(m) Sections 302 through 308, relating to minimum funding standards;

.02(n) Section 403(c)(1), relating to the purposes for which plan assets must be held;

.02(o) Section 404(a), relating to fiduciary duties as applied to particular conduct; and,

.02(p) Section 407(a)(2) and (3) and (d)(1), relating to fair market value, as applied to whether the value of any particular security or real property constitutes fair market value.

This list is not all inclusive and the Department may decline to issue advisory opinions relating to other sections of the Act whenever warranted by the facts and circumstances of a particular case. The Department may, when it is deemed appropriate and in the best interest of sound administration of the Act, issue information letters calling attention to established principles under the Act, even though the request that was submitted was for an advisory opinion.

.03 Pending the adoption of regulations (either temporary or final) involving the interpretation of the application of a provision of the Act, consideration will be given to the issuance of advisory opinions relating to such provisions of the Act only under the following conditions:

.03(a) If an inquiry presents an issue on which the answer seems to be clear from the application of the provisions of the Act to the facts described, the advisory opinion will be issued in accordance with the procedures contained herein.

.03(b) If an inquiry presents an issue on which the answer seems reasonably certain but not entirely free from doubt, an advisory opinion will be issued only if it is established to the satisfaction of the Department, that a business emergency requires an advisory opinion or that unusual hardship to the plan or its participants and beneficiaries will result from failure to obtain an advisory opinion. In any case in which the individual or organization believes that a business emergency exists or that an unusual hardship to the plan or its participants and beneficiaries will result from the failure to obtain an advisory opinion, the individual or organization should submit with the request a separate letter setting forth the facts necessary for the Department to make a determination in this regard. In this connection, the Department will not deem a "business emergency" to result from circumstances within the control of the individual or organization such as, for example, scheduling within an inordinately short time the closing date of a transaction or a meeting of the Board of Directors or the shareholders of a corporation.

.03(c) If an inquiry presents an issue that cannot be reasonably resolved prior to the issuance of a regulation, an advisory opinion will not be issued.

.04 The Department ordinarily will not issue advisory opinions on the form or effect in operation of a plan, fund, or program (or a particular provision or provisions thereof) subject to Title I of the Act. For example, the Department will not issue an advisory opinion on whether a plan satisfies the requirements of Parts 2 and 3 of Title I of the Act.

SEC. 6. *Instructions to individuals and organizations requesting advisory opinions from the Department.* .01 If an advisory opinion is desired, a request should be submitted to: Advisory Opinion, Office of Regulatory Standards and Exceptions, Pension and Welfare Benefit Programs, U.S. Department of Labor, Washington, D.C. 20216.

.02 A request for an advisory opinion must contain the following information:

.02(a) The name and type of plan or plans (e.g., pension, profit-sharing, or welfare plan); the Employer Identification Number (EIN); the Plan Number (PN) used by the plan in reporting to the Department of Labor on Form EBS-1; or a copy of the first two pages of the most recent Form EBS-1 filed with the Department.

.02(b) A detailed description of the act or acts or transaction or transactions with respect to which an advisory opinion is requested. Where the request pertains to only one step of a larger integrated act or transaction, the facts, circumstances, etc., must be submitted with respect to the entire transaction. In addition, a copy of all documents submitted must be included in the individual's or organization's statement and not merely incorporated by reference, and must be accompanied by an analysis of their bearing on the issue or issues, specifying the pertinent provisions.

.02(c) A discussion of the issue or issues presented by the act or acts or transaction or transactions which should be addressed in the advisory opinion.

.02(d) If the individual or organization is requesting a particular advisory opinion, the requesting party must furnish an explanation of the grounds for the request, together with a statement of relevant supporting authority. Even though the individual or organization is urging no particular determination with regard to a proposed or prospective act or acts or transaction or transactions, the party requesting the ruling must state such party's views as to the results of the proposed act or acts or transaction or transactions and furnish a statement of relevant authority to support such views.

.03 A request for an advisory opinion by or for an individual or organization must be signed by the individual or organization or by the individual's or organization's authorized representative. If the request is signed by a representative of an individual or organization, or the representative may appear before the Department in connection with the request, the request must include a statement that the representative is authorized to represent the individual or organization.

.04 A request for an advisory opinion that does not comply with all the provisions of this procedure will be acknowledged, and the requirements that have not been met will be noted. Alternatively, at the discretion of the Department, the Department will issue an information letter to the individual or organization.

.05 If the individual or organization, or the authorized representative, desires a conference in the event the Department contemplates issuing an adverse advisory opinion, such desire should be stated in writing when filing the request or soon thereafter in order that the Department may evaluate whether in the sole discretion of the Department a conference should be arranged and at what stage of the consideration a conference would be most helpful.

.06 It is the practice of the Department to process requests for information letters and advisory opinions in regular order and as expeditiously as possible. Compliance with a request for consideration of a particular matter ahead of its regular order, or by a specified time, tends to delay the disposition of other matters. Requests for processing ahead of the regular order, made in writing (submitted with the request or subsequent thereto) and showing clear need for such treatment, will be given consideration as the particular circumstances warrant. However, no assurance can be given that any letter will be processed by the time requested. The Department will not consider a need for expedited handling to arise if the request shows such need has resulted from circumstances within the control of the person making the request.

.07 An individual or organization, or the authorized representative desiring to obtain information relating to the status of his or her request for an advisory opinion may do so by contacting the Office of Regulatory Standards and Exceptions, Pension and Welfare Benefit Programs, U.S. Department of Labor, Washington, D.C.

SEC. 7. *Instructions to individuals and organizations requesting advisory opinions relating to prohibited transactions and common definitions.* .01 [Reserved]

.02 [Reserved]

.03 [Reserved]

SEC. 8. *Conferences at the Department of Labor.* If a conference has been requested, and the Department determines that a conference is necessary or appropriate, the individual or organization or the authorized representative will be notified of the time and place of the conference. A conference will normally be scheduled only when the Department in its sole discretion deems it will be necessary or appropriate in deciding the case. If conferences are being arranged with respect to more than one request for an opinion letter involving the same individual or organization, they will be so scheduled as to cause the least inconvenience to the individual or organization.

SEC. 9. *Withdrawal of requests.* The individual or organization's request for an advisory opinion may be withdrawn at any time prior to receipt of notice that the Department intends to issue an adverse opinion, or the issuance of an opinion. Even though a request is withdrawn, all correspondence and exhibits will be retained by the Department and will not be returned to the individual or organization.

SEC. 10. *Effect of Advisory Opinion.* An advisory opinion is an opinion of the Department as to the application of one or more sections of the Act, regulations promulgated under the Act, interpretive bulletins, or exemptions. The opinion assumes that all material facts and representations set forth in the request are accurate, and applies only to the situation described therein. Only the parties described in the request for opinion may rely on the opinion, and they may rely on the opinion only to the extent that the request fully and accurately contains all the material facts and representations necessary to issuance of the opinion and the situation conforms to the situation described in the request for opinion.

SEC. 11. *Effect of Information Letters.* An information letter issued by the Department is informational only and is not binding on the Department with respect to any particular factual situation.

SEC. 12. *Public inspection.* .01 Advisory opinions shall be open to public inspection at the Public Disclosure Room, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20216.

.02 Background files (including the request for an advisory opinion, correspondence between the Department and the individual or organization requesting the advisory opinion) shall be available upon written request. Background files may be destroyed after three years from the date of issuance.

.03 Advisory opinions will be modified to delete references to proprietary information prior to disclosure. Any information considered to be proprietary should be so specified in a separate letter at the time of request. Other than proprietary information, all materials contained in the public files shall be available for inspection pursuant to section 12.02.

.04 The cost of search, copying and deletion of any reference to proprietary information will be borne by the person requesting the advisory opinion or the background file.

SEC. 13. *Effective date.* This procedure is effective August 27, 1976, the date of its publication in the FEDERAL REGISTER.

Signed at Washington, D.C., this 24th day of August 1976.

JAMES D. HUTCHINSON,
*Administrator of Pension and Welfare Benefit Programs, U.S. Department of Labor.*

[FR Doc.76-25108 Filed 8-26-76;8:45 am]

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## Occupational Safety and Health Administration

[V-76-18]

## AMERICAN TOBACCO CO.

### Application for Variance and Interim Order; Grant of Interim Order

1. *Notice of Application.* Notice is hereby given that the American Tobacco Company, 245 Park Avenue, New York, New York 10017 has made application pursuant to section 6(d) of the Occupational Safety and Health Act of 1970 (84

cords Authentication Certificate U.S. Department of Labor

DLMS 1

ction A. Legal Custodian Appendix A-904

HEREBY ATTEST. That the attached copy or copies of each document listed below is a true copy of a ument in the official custody of the Department of Labor.

Opinion 89-33A dated December 12, 1989

| and Official Title | Agency and Office | Date |
|---|---|---|
| J. Doyle, Director, Office<br>lations and Interpretations | Office of Regulations and Interpretations<br>Pension and Welfare Benefits Administration | February 9, 1990 |

Authentication Officer

I HEREBY CERTIFY, That Robert J. Dovle who signed the foregoing attestation, is now and was at the time of signing (title) Director of Regulations and Interpretations and has legal custody of the official records of the United States Department of Labor therein attested and that full faith and credit should be given to his/her act as such.

IN WITNESS WHEREOF, I

June E. Patron, Director of Program Services

duly designated by the Secretary of Labor as Authentication Officer of the Department of Labor, have here-unto subscribed my name and caused the seal of the Department of Labor to be affixed this 9th day of February 9th 19 90.

June E Patron

Authentication Officer
Department of Labor

ATTACHMENT II

.S. Department of Labor

Pension and Welfare Benefits Administration
Washington, D.C. 20210

89-33A

DEC 12 ....

Mr. L. J. Darter, III
Georgia Insurance Commission
Seventh Floor, West Tower
Floyd Building
2 Martin Luther King, Jr., Drive
Atlanta, Georgia 30334

Dear Mr. Darter:

This is in reply to your request for an advisory opinion regarding the applicability of title I of the Employee Retirement Income Security Act of 1974 (ERISA). Specifically, you ask whether the National Business Association Trust (NBAT) is an employee welfare benefit plan within the meaning of section 3(1) of title I of ERISA and whether NBAT is a multiple employer welfare arrangement (MEWA) within the meaning of section 3(40) of that title.

You advise that NBAT was created pursuant to a trust agreement dated July 24, 1987, between the Coca-Cola Bottling Co. of S.E. Missouri and other unnamed corporations as the Company and Charles Sander as Trustee. The trust agreement states that it is an amendment of and successor to the Mid America Soft Drink Bottling Trust. The trust agreement states that the Company intends to adopt health care and welfare plans for the benefit of its employees and that it provides for the creation of a MEWA within the meaning of section 3(40) of title I of ERISA. The term "Company" is defined to include all employers which thereafter participate in NBAT. There are approximately 68 employers utilizing NBAT to provide medical coverage to their employees. In a telephone conversation with John Keene of this Office, you also stated that the employers utilizing NBAT to provide benefits to their employees do not constitute a controlled group and that NBAT is not maintained pursuant to any collectively bargained agreement.

Section 3(40)(A) of title I of ERISA defines the term "MEWA" to include:

> . . .an employee welfare benefit plan, or any other arrangement (other than an employee welfare benefit plan), which is established or maintained for the purpose of offering or providing any benefit described in paragraph (1) to the employees of two or more employers (including one or more self-employed individuals), or to their beneficiaries, except that such term does not include any such plan or other arrangement which is established or maintained--

> (i) under or pursuant to one or more agreements which the Secretary finds to be collective bargaining agreements, or
>
> (ii) by a rural electric cooperative.

Based upon the information you submitted, it is the position of the Department of Labor (the Department) that NBAT is a MEWA within the meaning of section 3(40). NBAT covers the employees of more than two separate, independent employers; is not maintained by a rural electric cooperative; and is not maintained under or pursuant to any collective bargaining agreement.

Although section 514(a) of ERISA provides that any state law or regulation which relates to an employee benefit plan covered by ERISA is preempted, P.L. 97-473 amended section 514(b) of title I of ERISA to provide:

> (6)(A) Notwithstanding any other provision of this section-- (i) in the case of an employee welfare benefit plan which is a multiple employer welfare arrangement and is fully insured (or which is a multiple employer welfare arrangement subject to an exemption under subparagraph (B)), any law of any State which regulates insurance may apply to such arrangement to the extent that such law provides--
>
> (I) standards, requiring the maintenance of specified levels of reserves and specified levels of contributions, which any such plan, or any trust established under such a plan, must meet in order to be considered under such law able to pay benefits in full when due, and
>
> (II) provisions to enforce such standards, and
>
> (ii) in the case of any other employee welfare benefit plan which is a multiple employer welfare arrangement, in addition to this title, any law of any State which regulates insurance may apply to the extent not inconsistent with the preceding sections of this title.
>
> (B) The Secretary may, under regulations which may be prescribed by the Secretary, exempt from subparagraph (A)(ii), individually or by class, multiple employer welfare arrangements which are not fully insured. Any such exemption may be granted with respect to any arrangement or class of arrangements only if such arrangement or each arrangement which is a member of such class meets the requirements of section 3(1) and section 4 necessary to be considered an employee welfare benefit plan to which this title applies.

Although section 514(b)(6)(B) provides that the Secretary of Labor may prescribe regulations under which the Department may exempt MEWAs from state regulation under section 514(b)(6)(A)(ii), the Department has previously stated that it did not see the need

to prescribe regulations under section 514(b)(6)(B) to exempt MEWAs from state regulation. The Department, at this time, has not changed its position. Accordingly, the Department is not providing MEWAs exemptions under section 514(b)(6)(B) from state regulation.

It is, therefore, the Department's position that NBAT is subject to state regulation at least to the extent provided in section 514(b)(6)(A), regardless of whether it is an employee benefit plan covered by title I of ERISA, because it is a MEWA within the meaning of section 3(40) of that title.

Because your request for an advisory opinion was concerned primarily with the issue of whether or not NBAT is subject to the applicable regulatory authority of the State of Georgia's insurance laws or is saved from such authority under the general preemption provision of section 514(a) of title I of ERISA, and because of the opinion above, we have determined it is not necessary at this time to render an opinion as to whether NBAT is an employee welfare benefit plan within the meaning of section 3(1) of that title.

The preceding constitutes an advisory opinion under ERISA Procedure 76-1. Accordingly, it is issued subject to the provisions of that procedure, including section 10 thereof relating to the effect of advisory opinions.

Sincerely,

Robert J. Doyle
Director of Regulations and Interpretations

Question: What is the current number of open criminal investigations as a percentage of total open investigations?

Answer:

As of the close of the first quarter of 1990 (3/31/90), PWBA had 1,676 open investigations. Sixty-eight of these investigations are criminal investigations, which represents 4.1% of the total number of open investigations.

Question: Review the Report of the President's Commission on Organized Crime and give the status of PWBA's implementation of the recommendations.

Answer:

The Department completed a detailed review of the recommendations of the Report of the President's Commission on Organized Crime. We are pleased to report that many of the Commission's recommendations have been adopted by the Department and we believe their implementation will enhance our ability to eliminate organized crime involvement with employee benefit plans.

Recommendations adopted by the Department include the implementation of an ERISA database which provides instant access to the Form 5500 by Area offices and data for the development of enforcement strategies. In addition, revisions have been made to the Form 5500 to make it a more effective enforcement tool by gathering detailed employee benefit plan information, particularly with respect to service providers. Finally, as announced in the President's budget request, the Department is seeking 100 new positions for ERISA enforcement which will enable PWBA to conduct as many as 1,000 more on-site investigations a year. The President's budget request is significant because the frequency of such examinations of employee benefit plans is directly related to the resources available to the agency.

While the Department has already implemented many of the Commission's recommendations, additional recommendation are currently under review by the Department. Pursuant to the Secretary's directive, the Department is in the process of reviewing all civil and criminal enforcement activities. Particular emphasis has been placed on the coordination of civil and criminal enforcement and their proper roles within the Department's overall enforcement strategy. We would also note that representatives from the Department of Labor and the Department of Justice have served on a joint task force to discuss implementation of the Commission's recommendations. As a result of these discussions, several other recommendations are currently being considered in the context of ongoing policy discussions within the Administration.

**Senate Permanent Subcommittee on Investigations**

**EXHIBIT #** 31

## PENSION WELFARE BENEFITS ADMINISTRATION

### DATA FOR FY-85 TO FY-89

Source: U.S. Department of Labor FY-87-91 Congressional Budget Submissions

| FYs | % | Actual Criminal Investigations Processed | Actual Total Field Investigations Processed |
|---|---|---|---|
| 85 | 2.0% | 35 | 1,675 |
| 86 | 2.7% | 47 | 1,687 |
| 87 | 1.4% | 5 | 1,758 |
| 88 | 1.4% | 23 | 1,610 |
| 89 | 1.8% | 28 | 1,581 |
| Total | 1.9% | 158 | 8,311 |

STATE OF CALIFORNIA

GEORGE DEUKMEJIAN, Governor

**DEPARTMENT OF INSURANCE**
100 VAN NESS AVENUE
SAN FRANCISCO, CALIFORNIA 94102

VIA FEDERAL EXPRESS

**Senate Permanent Subcommittee on Investigations**

**EXHIBIT #** 33

May 15, 1990

RECEIVED BY
SENATE PERMANENT
SUBCOMM ON INVESTIGATIONS
MAY 18 1990
[illegible] OFFICE

The Honorable Sam Nunn, Chairman
Permanent Subcommittee on Investigations
Committee on Governmental Affairs
United States Senate
Washington, D.C. 20510-6250

Dear Senator Nunn:

The California Department of Insurance welcomes the opportunity to present testimony to the Investigations Subcommittee of the Senate Committee on Governmental Affairs. As we understand your letters of March 27, and May 1, 1990, and conversations with your staff, the subcommittee solicits our comments concerning abuses by multiple employer health insurance trusts (METS) and multiple employer welfare arrangements (MEWAs), focusing on the following areas:

* Facts of the problem
* Effectiveness of the regulatory and enforcement programs of the United States Departments of Labor and Justice in connection with abuses by METS and MEWAs.
    * Do the programs effectively identify fraud and abuse by METS and MEWAs?
    * What is the response to criminal allegations?
    * Are there coordination problems among federal law enforcement agencies and among state and federal agencies?
* Problems in trying to prosecute MET and MEWA operators.
* Problems in determining whether or not an entity is a MEWA under the Employee Retirement Income Security Act (ERISA).
* Recommendations

## FACTS

In California, we have seen four serious types of abuse involving METS or MEWAs.

1. A plan claims to be a MEWA fully qualified under ERISA, but is improperly administered or underfunded, or funds are misappropriated or stolen out of the trust.

2. A plan represents that it is an insured plan in order to induce the buyer's confidence. In reality, the insurance policy does not provide primary insurance and will never pay through to the employees.

3. A plan is controlled by an administrator which insures the plan with a small, unlicensed or offshore insurer also controlled by the administrator. The insurer's portfolio consists of either inadequate or bogus assets.

4. A plan is controlled by an administrator which insures the plan with an existing licensed insurer with cash flow or solvency problems. The administrator sets the rates and pays claims. The rates are inadequate thus drawing the insurer into further financial difficulty, and/or claims funds are diverted by the administrator. The administrator may fraudulently conceal from the insurer premiums collected or business written. Consequently, the insurer has the liability without the corresponding assets.

As the scenarios play out, insureds: are frequently left without coverage; have claims unfairly denied; have premiums intended for their benefit diverted to unreasonably high administrative expenses or stolen outright; may be rolled from one unstable plan to another; and are ultimately left without insurance or coverage of any kind. Insureds unfortunate enough to have medical conditions are not only without insurance coverage for current claims, but may also be precluded from ever securing insurance coverage again.

Abusive, unregulated, underfunded and sometimes criminally oriented health coverage plans spring up where major health insurers pull out of the market place or health insurance is simply unaffordable for small business employers. The vacuum is filled by entrepreneurs -- general agents and administrators controlling blocks of small employers who can not find or afford health insurance for their employees. There are 27 investigations of alleged fraud now open in California.

The criminal element engaged in these enterprises has great staying power and great mobility. The abuses will not be stopped by civil actions; there must be criminal prosecutions.

## EFFECTIVENESS OF FEDERAL REGULATORY AND ENFORCEMENT PROGRAMS

### Do Programs Effectively Identify Fraud Abuse?

Because communication between state and federal agencies is limited, our knowledge of identification of fraud and abuse by the federal agencies is also limited. We have no information that the Department of Labor has made any effort to identify MET and MEWA fraud independent of state regulators. Until recently, the Department of Labor consistently took the position that METS and illegal ERISA plans were a state regulatory problem.

### What Is The Response By Federal Agencies To Allegations Of Criminal Conduct In METS And MEWAs

In our view, the United States Department of Labor has neither effectively regulated or prosecuted conduct by the outlaw element of an industry spawned by federal law.

First, we observe that when the Pension Welfare and Benefit Administration (PWBA) was given responsibility for regulating MEWAs and METS, the volume and the severity of fraud and abuse cases that have actually come to light was never foreseen. Consequently, it appears that the commitment of resources and the level of funding were inadequate.

Further, it appears that the respective responsibilities and jurisdictions of the Office of the Inspector General (OIG) and the PWBA within the Department of Labor must be redefined to promote the effective and frequent prosecution of complex criminal cases.

Finally, the department has been very slow to issue its opinions, yet holds out these opinions as its contributions to a solution to the problems.

Until recently, the role of the Department of Justice in prosecuting MET/MEWA cases has been problematical. Although the Department of Labor took the position that illegal MET/MEWA operations were the states' business, our experience was that federal prosecutors (and state and federal judges, as well) regarded the federal ERISA exemption broad enough to preclude state action against METS and MEWAs altogether.

As a practical matter, it is unlikely that these cases will be brought by state agencies in the near future. For a variety of reasons, local district attorneys will not touch them, and the California Attorney General has only lately become interested in them.

If cases are to be prosecuted, they must be brought by federal prosecutors in the federal courts. In recent months, some California U.S. Attorney offices have shown a willingness to consider prosection of such cases, the result of direct overtures from the California Department of Insurance and the OIG.

### Are There Coordination Problems Among Agencies?

State-federal cooperation is emerging, but is still largely without results. A multi-level national intelligence network and joint investigations are needed.

Federal structures and procedures impede the sharing by federal agencies of information with state regulators. Federal agencies state that they are legally precluded from providing leads or information to other regulatory or enforcement agencies concerning ongoing investigations. But the fact is that, given the short life of the scams (they exist only as long as it takes for the funds to run out or be diverted), the staying power of the perpetrators (they roll from one operation to the next), and the mobility of the bad actors, only interagency cooperation will bring the desired outcome. Without such cooperation, results are neither timely nor commensurate with the magnitude of the problem.

## PROBLEMS IN PROSECUTING MET/MEWA OPERATORS

Some of the difficulties in prosecuting the MET/MEWA cases are covered above, but a summary follows.

- It appears that cases are not prosecuted at the federal level because the cases are not "ready." The response to our inquiries about why the cases are not yet finished is "a lack or resources."
- At the state level, it has been impossible to persuade prosecutors to take MET/MEWA cases. Local district attorneys are understaffed in relation to staff required to prosecute major fraud cases. The only viable state prosecutors are in the California Attorney General's Office. They are just now becoming involved in the criminal prosecution of these cases.
- Lack of cooperation among agencies has made developing cases more difficult and time consuming than it should be. By the time a case is developed, the MET/MEWA operator has moved on and is working a new operation.

We are extremely encouraged by the establishment by the United States Department of Labor and the United States Attorney's Office for the Central District of California of a working group to handle MET/MEWA cases on a formal ongoing basis. The working group involves the sharing of confidential information and responsibilities among a fixed group of attorneys and investigators.

## PROBLEMS IN IDENTIFYING MEWAS UNDER ERISA

The problems of identifying MEWAs subject to ERISA have been largely overcome. We are confident that we can support our position: that if an entity "walks and quacks" like an insurance entity, it is an insurance entity, and therefore subject to the jurisdiction of the state. Even if it is a plan subject to ERISA, it is also subject to state insurance regulations to the extent that such regulation is not inconsistent with ERISA. (A memorandum of points and authorities submitted in the case of Association Benefits Trust Health and Welfare Plan v. Roxani M. Gillespie, Insurance Commissioner, State of California accompanies these comments for your further information on this subject.)

Nevertheless, a revision of ERISA provisions to make the state's position and its authority with respect to METS and MEWAs crystal clear, would be welcome.

## RECOMMENDATIONS

1. Clarify assignment of responsibilities for civil and criminal MET/MEWA cases among the federal agencies.
2. Commit resources to the development and prosecution of cases commensurate with the abuses in the field.
3. Support interagency cooperation with policy and resources.
4. Make Department of Labor staff available for conferences with federal and state judges to educate them on the current provision of the federal preemption.
5. Amend ERISA to clarify the states' authority with respect to METS and MEWAs.

Our goal is to identify fraud and abuse in the early stages, secure the funds before they are depleted, and prosecute criminal activity. The California Department of Insurance is sponsoring a regional task force to coordinate the investigative and prosecutorial efforts among state and federal agencies to achieve this goal. The U. S. Attorneys' Office in Atlanta is sponsoring an effort to accomplish the same objective nationwide. The process in interagency cooperation cultivated by these programs is encouraging.

We are gratified that the subcommittee is taking an interest in the regulation and enforcement problems associated with METS and MEWAs. My staff is ready to assist you in any way possible.

Sincerely,

Roxani M. Gillespie

Roxani M. Gillespie,
Insurance Commissioner

RMG/mbs

JOHN K. VAN DE KAMP, Attorney General
of the State of California
EDMOND B. MAMER,
Supervising Deputy Attorney General
RAYMOND B. JUE, Bar No. 061656
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3580 Wilshire Boulevard, Suite 900
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Telephone: (213) 736-2038

Attorneys for Defendant

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CHAMBERS OF
SENIOR JUDGE IRVING HILL

## UNITED STATES DISTRICT COURT

## CENTRAL DISTRICT OF CALIFORNIA

ASSOCIATION BENEFITS TRUST HEALTH AND WELFARE PLAN; ASSOCIATION BENEFIT SERVICES, INC.; NATIONAL FAMILY BUSINESS ASSOCIATION, INC.; MICHAEL ALAN RUBELL; JAMES BRIAN HELM; DAVID ERLANDSON; ROBIN H. DRIVER; and RUBELL HELM INSURANCE SERVICES, INC.,

Plaintiffs,

v.

ROXANI M. GILLESPIE, Insurance Commissioner, STATE OF CALIFORNIA,

Defendant.

Case No. 89-5641 IH

MEMORANDUM OF POINTS AND AUTHORITIES IN OPPOSITION TO APPLICATION FOR TEMPORARY RESTRAINING ORDER

JOHN K. VAN DE KAMP, Attorney General
of the State of California
EDMOND B. MAMER,
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SENIOR JUDGE IRVING HILL

UNITED STATES DISTRICT COURT

CENTRAL DISTRICT OF CALIFORNIA

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| ASSOCIATION BENEFITS TRUST HEALTH AND WELFARE PLAN; ASSOCIATION BENEFIT SERVICES, INC.; NATIONAL FAMILY BUSINESS ASSOCIATION, INC.; MICHAEL ALAN RUBELL; JAMES BRIAN HELM; DAVID ERLANDSON; ROBIN H. DRIVER; and RUBELL HELM INSURANCE SERVICES, INC.,<br>Plaintiffs,<br>v.<br>ROXANI M. GILLESPIE, Insurance Commissioner, STATE OF CALIFORNIA,<br>Defendant. | Case No. 89-5641 IH<br>MEMORANDUM OF POINTS AND AUTHORITIES IN OPPOSITION TO APPLICATION FOR TEMPORARY RESTRAINING ORDER |

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## PRELIMINARY STATEMENT

Pursuant to the request and direction of the court, defendant Insurance Commissioner submits this memorandum on the following issues: (1) whether the authority of the Insurance Commissioner to regulate plaintiffs has been preempted by the Employee Retirement Income Security Act of 1974 ("ERISA"), 29

U.S.C. § 1001 et seq. and (2) whether Insurance Code § 1065.2 is violative of due process.

## I

## THE COMMISSIONER'S ORDER IS NOT PREEMPTED BY ERISA

Plaintiffs claim that Association Benefits Trust Health and Welfare Plan (ABT) is an employee welfare benefit plan within the meaning of § 1002(1) of ERISA. Defendant alleges that ABT is a multiple employer trust offering life and health benefits in the State of California and that it is not an employee welfare benefit plan under ERISA. Further, defendant asserts that even if ABT was an employee welfare benefit plan, ABT would fall within the definition of a multiple employer welfare arrangement defined in § 1002(40) of ERISA, and is subject to state insurance regulation since ABT does not offer a fully insured plan.

At the administrative hearing called for in the Commissioner's order, it would be established that the health and life benefits offered by ABT are marketed in the same manner as life and health insurers market their insurance products, through insurance agents who are paid on a commission basis by ABT. The insurance program of ABT is marketed and administered by Association Benefit Services, Inc. ("ABS"), an entity owned and controlled by James Helm and Michael Rubell, for the profit of ABS and its principals. The benefits of ABT are offered to anyone engaged in any particular trade or profession, regardless of commonality among the employer members. The control of ABT is vested in ABS and its principals. The employer members had no part in the establishment of ABT and have no control over ABT or

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the benefits being offered.

29 U.S.C. § 1002(1) of ERISA defines the term "employee welfare benefit plan" to include:

> ". . . any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services, or (B) any benefit described in section 302(c) of the Labor Management Relations Act, 1947 (other than pensions on retirement or death, and insurance to provide such pensions)."

Thus, to be an employee welfare benefit plan within the meaning of section 1002(1), an entity must not only provide benefits among those described in that section but also, among other criteria, be established or maintained by an employer, an employee organization, or both.

The terms "employee organization" and "employer" are defined in 29 U.S.C. §§ 1002(4) and 1002(5) respectively as follows:

> "(4) The term 'employee organization' means any labor

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union or any organization of any kind, or any agency or employee representation committee, association, group, or plan, in which employees participate and which exists for the purpose, in whole or in part, of dealing with employers concerning an employee benefit plan, or other matters incidental to employment relationships; or any employees' beneficiary association organized for the purpose in whole or in part, of establishing such a plan.

(5) The term 'employer' means any person acting directly as an employer, or indirectly in the interest of an employer, in relation to an employee benefit plan; and includes a group or association of employers acting for an employer in such capacity."

ABT does not claim that an employee organization is in any way involved in the establishment or maintenance of the Trust or the extension of benefits of the Trust to the participants. Therefore, if ABT does not come within the definition of "employer," it cannot be an employee welfare benefit plan.

The definitional provisions of ERISA recognize that a single employee welfare benefit plan might be established or maintained by a cognizable, bona fide group or association of "employer", within the meaning of section 1002(5), acting in the interests of its employer members to provide benefits for their employees. On the other hand, where several unrelated employers merely execute similar documents or otherwise participate in an arrangement as a means to fund benefits, in the absence of any genuine organization relationship among the employers, no employer association, and consequently no employee welfare benefit plan, can be recognized.

ABT falls within this category. ABT was not established and is not maintained or controlled by the employers within ABT. The employers who enroll in ABT simply are looking for the life and health benefits offered by the Trust.

At best, ABT's operation can be best characterized as a "MET" or "multiple employer trust," a loosely-defined phrase not used in ERISA but which connotes an entity formed or used by a promoter to sell benefit coverage to unrelated groups or individuals.

Congress, when it enacted ERISA, never intended that an entity established to sell benefit coverage would ever be thought of as an ERISA plan. Upon learning of claims that certain METs were ERISA plans, the House Committee on Education and Labor - the committee responsible for the House version of Title 1 of ERISA - rejected the MET promoters' contentions with the following statement:

> "It has come to our attention, through the good office of the National Association of State Insurance Commissioners, that certain entrepreneurs have undertaken to market insurance products to employers and employees at large, claiming these products to be ERISA covered plans. For instance, persons whose primary interest is in profiting from the provision of administrative services are establishing insurance companies and related enterprises. The entrepreneur will then argue that this enterprise is an

ERISA benefit plan which is protected, under ERISA's preemption provision, from state regulation. We are concerned with this type of development, but on the basis of the facts provided us, we are of the opinion that these programs are not 'employee benefit plans' as defined in Section 3(3). _As described to us, these plans are established and maintained by the entrepreneurs for the purpose of marketing insurance products or services to others._. They are not established or maintained by the appropriate parties to confer ERISA jurisdiction, nor is the purpose for their establishment or maintenance appropriate to meet the jurisdictional prerequisites of the Act. _They are no more ERISA plans than is any other insurance policy sold to an employee benefit plan_. To the extent that such programs fail to meet the definition of an 'employee benefit plan,' state regulation of them is not preempted by section 514, even though such state action is barred with respect to the plans which purchase these products."[1] (Emphasis added.)

Although this report is not part of ERISA's legislative history, it was prepared shortly after ERISA's enactment and represents not mere isolated comments of individual members but the view of an entire influential Committee under the leadership which existed at the time of ERISA's passage. (See _Sutherland, Statutory Construction_, 4th Ed., Vol. 2A, $ 49.06. _Cf. United_

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[1] _The Activity Report of the House Committee on Education and Labor_, House Report No. 94-1785, January 3, 1977.

*States* v. *Mine Workers* (1947) 330 U.S. 258, 282; *Rainwater* v. *United States* (1958) 356 U.S. 590.) Accordingly, it has been properly relied on by several courts which have, without exception, rejected the claims of MET promoters that under a literal reading of ERISA's definitional provisions, their entities were "plans." (See *Bell* v. *Employee Sec. Ben. Assn.* (D. Kan. 1977) 437 F.Supp. 382; *National Business Conference* v. *Anderson* (S.D. Iowa, 1977) 451 F.Supp. 458; *Hamberlin* v. *VIP Insurance Trust* (D. Arizona 1977) 434 F.Supp. 1196; *Taggart Corp.* v. *Life Health Benefit Admin*. (5th Cir. 1980) 617 F.2d 1208, *cert. denied*. 450 U.S. 1030.)

*If an entity sells a contact indemnifying against contingent loss, it is an insurer subject to state insurance regulation*. There is an exception provided under federal law for a qualifying ERISA trust. However, this exception is limited and an entity which fails to comply with the state qualifications is appropriately classified as an insurance company. More specifically, courts throughout the country have consistently held that self-funded METs, such as ABT, are insurers and subject to state law.

In *Wayne Chemical, Inc.* v. *Columbus Agcy. Serv. Corp.* (7th Cir. 1977) 567 F.2d 692, an employer, one of its employees and the latter's crippled son sued an insurance brokerage company under state law. The brokerage company had placed the employer's group medical coverage with a self-funded MET, which became insolvent. Indiana insurance law provided that anyone who aided the sale of insurance by an *unlicensed insurer* was liable for the

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unpaid benefits, if such insurer defaulted. The district court held for the plaintiffs.

The Court of Appeal affirmed. It noted that initially the insurance coverage had been underwritten by a legitimate licensed insurance company. However, shortly before the employee's son's crippling accident, the insurance had been moved to a new carrier, which turned out to be a self-funded MET, known as the NMEF trust. (Wayne Chemical, supra, at 696.) The court held at pages 696 and 697 that, unless the NMEF trust was a legitimate ERISA trust and thus subject exclusively to federal regulation due to ERISA's preemption provision, the NMEF trust was an insurer subject to state law:

> "Transaction of insurance business in Indiana without a certificate of authority from the Commissioner of Insurance is forbidden, with certain exceptions. [Citation omitted.] It appears to be undisputed that, neither NMEF nor the trust created by the agreement just described had an Indiana Certificate, and that unless they were protected by the preemption provisions of ERISA, they were in violation of the Indiana unauthorized insurance statute."

The court in Wayne Chemical further determined that the NMEF trust was not an employee benefit plan pursuant to ERISA, and thus the brokerage would be liable for the unpaid medical benefits. (Wayne Chemical, supra, at 700.)

Similarly, in Bell v. Employee Sec. Ben. Assn., supra, 437 F.Supp. 382, the Kansas insurance commissioner sought injunctive relief against a self-funded MET based upon the conclusion that it was an insurer subject to state regulation. The court agreed and stated that this MET was the same as "any other insurance company selling medical care benefits to working individuals". (Bell, supra at 396; Accord, Hamberlin v. VIP Insurance Trust, supra, 434 F.Supp. 1196.)

ABT was and is an insurer precisely like the MET's involved in Wayne Chemical, Bell and Hamberlin. Because ABT (1) provides health coverage to wide and unrelated groups of employees (2) markets its coverage exactly like other health insurers and (3) was established to provide profit to its administrators. ABT cannot claim ERISA status. ABT is and always has been acting as an unlicensed insurer.

### A. The McCarran-Ferguson Act Gives to the State of California the Authority to Regulate ABT's Insurance Business

The McCarran-Ferguson Act, 15 United States Code sections 1011 et seq., provides that the regulation and taxation of the business of insurance shall be subject to state law, and that any state law regulating or taxing the business of insurance shall not be impaired unless a federal act specifically relates to the business of insurance.

Congress passed the McCarran-Ferguson Act because it believed that the business of insurance was "a local matter, to be subject to and regulated by the laws of the several states." (H.R.Rep. No. 143, 79th Cong., 1st Sess., 2 (1945); Western & Southern L.I. Co. v. Bd. of Equalization (1980) 451 U.S. 648, 654.) "The unequivocal language of the Act suggests no exceptions." (Id., at 653.) It was passed to insure that the states should be permitted to continue regulating and taxing the insurance industry. (Feinstein v. Nettleship Co. of Los Angeles (9th Cir. 1983) 714 F.2d 928, 931; cert. denied (1984) 104 S.Ct. 2346.)

The McCarran-Ferguson Act contains three main provisions.

The first provision, section 1, sets forth the following Congressional declaration:

> "Congress declares that the continued regulation and taxation by the several states of the business of insurance is in the public interest, and that silence on the part of Congress shall not be construed to impose any barrier to the regulation or taxation of business business by the several states."[2] (15 U.S.C. § 1011.)

The second provision, section 2(a), provides as follows:

> "[t]he business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business." (15 U.S.C. § 1012(a).)

The third provision, section 2(b), provides as follows:

> "[n]o Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the

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2. The McCarran-Ferguson act was enacted in response to a 1944 Supreme Court holding that, contrary to long-existing precedent, the business of insurance was "commerce" under the Commerce Clause. By enacting the McCarran-Ferguson Act, Congress meant to preserve the business of insurance as a "'a local matter.'" (See Western & Southern, supra at 654-655.)

> purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance . . . ." (15 U.S.C., § 1012(b).)

The McCarran-Ferguson Act reaffirmed the national policy of allowing states to be dominant in the regulation of insurance. (See SEC v. National Securities, Inc. (1969) 393 U.S. 453, 458; Eversole v. Metroplitan Life Ins Co., Inc. (C.D. Calif. 1980) 500 F.Supp. 1162, 1168.)[3]

Thus, the Commissioner has full authority to regulate ABT's business of insurance unless Congress has specifically provided otherwise in ERISA. Congress has not provided otherwise in ERISA. Rather, ERISA has preserved the powers given to the States by the McCarran-Ferguson Act.

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[3] ERISA was enacted in a Commerce Clause context. Congress relied primarily on its power under the Commerce Clause when it promulgated ERISA. (See ERISA § 2, 29 U.S.C. § 1001.) This is important because the United States Supreme Court has held that "Congress removed all Commerce Clause limitations on the authority of the States to regulate and tax the business of insurance when it passed the McCarran-Ferguson Act. . . . " (Western & Southern L.I. Co. v. Bd. of Equalization (1980) 451 U.S. 648, 653; emphasis added.) In enacting the provisions of ERISA which are based primarily on Congress' Commerce Clause authority, Congress presumbably was aware that unless and to the extent that ERISA specifically impaired the power granted to the States to regulate the business of insurance, those powers would remain with the States.

### B. In its 1985 Metropolitan Decision, the United States Supreme Court Has Established That ERISA Does Not Take Away Any Powers Granted to the States Under McCarran-Ferguson But in Fact Reaffirms and Preserves Those Powers

The United States Supreme Court in its Metropolitan decision (Metropolitan Life Ins. Co. v. Mass. (1985) 105 S.Ct. 2380), has held that ERISA specifically preserves the powers held by the States under the authority of the McCarran-Ferguson Act; therefore, they are not preempted by ERISA. (Id., at p. 2392.) In that case, the Supreme Court held that a state may dictate the contents of an insurance policy which directly affects the benefits provided by an ERISA plan. (Id., at 2393.) Specifically, it upheld a state law which required that all health insurance policies include certain minimum mental health care benefits. (Ibid.)

In support of this holding, the court relied on the McCarran-Ferguson Act, ERISA's Saving Clause (ERISA, § 514(b)(2)(A), 29 U.S.C., § 1144(b)(2)(A)), and ERISA's Equal Dignity provision (ERISA, § 514(d), 29 U.S.C., § 1144(d)).

In order to understand the basis of the Supreme Court's decision, it is helpful to have an overview of ERISA and to review the sanctions of ERISA which deal with preemption and exemptions from preemptions.

ERISA was enacted primarily as pension reform legislation. The basic purpose of ERISA was to protect the millions of people who depend on benefits from private pensions plans for financial independence after retirement. (Stone v. Stone (N.D.Cal. 1978) 450 F.Supp. 919,, 926, aff'd. (9th Cir.

1980) 632 F.2d 740, cert. denied (1981) 453 U.S. 922.)

ERISA regulates both employee pension and employee welfare benefit plans, although it regulates the pension plans more extensively. Title 1 of ERISA has five main sub-parts. Part five is entitled Administration and Enforcement. The Preemption Clause, Saving Clause, Deemer Clause and Equal Dignity provision are all contained in Part 5.

The Preemption Clause, ERISA section 514(a), 29 United States Code section 1144(a), reads in relevant part as follows:

> "(a) Except as provided in subsection (b) of this section the provisions of this subchapter and subchapter III of this chapter shall supersede any and all state laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title."

The Saving Clause, ERISA section 514(b)(2)(A), 29 United States Code section 1144(b)(2)(A), is an exception to the Preemption Clause and reads in relevant part as follows:

> "(2)(A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking or securities." (Emphasis added.)

The Deemer Clause, ERISA section 514(b)(2)(B), 29 United States Code section 1144(b)(2)(B), reads in relevant part as follows:

> "(B) Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under

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> section 1003(b) of this title . . . nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies."

The Equal Dignity Clause, ERISA section 514(d), 29 United States Code section 1144(d), reads in relevant part as follows:

> "Nothing in [ERISA] shall be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States . . . ."

In the Metropolitan case, the United States Supreme Court interpreted the meaning of ERISA's Saving Clause. In so doing, the Court relied heavily on the principles which have been established under the McCarran-Ferguson Act and found that if a state regulates an insurance company under the authority of the McCarran-Ferguson Act, then such state laws are "saved" from ERISA's preemption section by the Saving Clause.

The Court recognized that Congress' "'primary concern'" in McCarran-Ferguson was "to 'insure that the States would continue to have the ability to tax and regulate the business of insurance.'" (Id., at 2392, n. 21.) The Court then noted that the McCarran-Ferguson language, i.e., "The business of insurance, . . . shall be subject to the laws of the several states which relate to the regulation or taxation of such business," is similar to ERISA's Saving Clause, and the Court stated as follows:

> "The ERISA Saving Clause, with its similarly worded protection of 'any law of any State which regulates insurance,' appears to have been designed to preserve the McCarran-Ferguson Act's reservation of the business of insurance to the States. The saving clause and the McCarran-Ferguson Act serve the same federal policy and utilize similar language to define what is left to the States." (Ibid; emphasis added.)

In other words, the powers granted to the states under ERISA's Saving Clause are just as broad as the powers granted to the states under the McCarran-Ferguson Act.

The Supreme Court also relied in part on ERISA's Equal Dignity Clause, ERISA section 514(d) 29 United States Code section 1144(d), to support its holding that ERISA does not alter, amend, modify, invalidate, impair or supersede the McCarran-Ferguson Act's granting of broad powers to the states over the business of insurance. (Ibid.)

It is clear from an analysis of the United States Supreme Court's Metropolitan decision and the ERISA statutes discussed above that state insurance statutes are not preempted by ERISA. Preemption under ERISA section 514(a), 29 United States Code section 1144(a), only applies if the broad terms of ERISA's Saving Clause, ERISA section 514(b)(2)(a), 29 United States Code section 1144(b)(2)(A) do not apply. However, in this case, the Saving Clause does apply.

ABT's proferred health coverage meant that it was transaction the business of insurance. The United States Supreme Court has held that under the McCarran-Ferguson Act the underwriting or spreading of risk is a characteristic of the business of insurance. (Metroplitan, supra, at 2391; Union Labor Life Ins. Co. v. Pireno (1982) 458 U.S. at 127-128; Group Life & Health Ins. Co. v. Royal Drug Co. (1979) 440 U.S. at 212; accord, Klamath-Lake Pharm. v. Klamath Med. Serv. Bureau (9th Cir. 1983) 701 F.2d 1276, 1285, cert. denied (1983) 464 U.S. 822.) Thus, by its own terms under the Savings Clause, ERISA did not preempt the Commissioner's regulatory efforts authority over ABT.

### C. Assuming Arguendo, That ABT Is Qualified Under ERISA, It Would Still Be Subject To Regulation by the Insurance Commissioner

Finally, even if it were assumed that ABT was an employee welfare benefit plan properly qualified under ERISA, state insurance laws would still be applicable to it. In 1983, Congress amended ERISA by adding 29 United States Code section 1144(b)(6)(A), which states:

> "Notwithstanding any other provision of this section -
>
> "(i) in the case of an employee welfare benefit plan which is a multiple employer welfare arrangement and is fully insured (or which is a multiple employer welfare arrangement subject to an exemption under subparagraph (B)), any law of any State which regulates insurance may apply to such arrangement to the extent that such law provides --
>
> "(I) standards, requiring the maintenance of specified levels of reserves and specified levels of

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contributions, which any such plan, or any trust established under such a plan, must meet in order to be considered under such law able to pay benefits in full when due, and

(II) provisions to enforce such standards, and

"(ii) in the case of any other employee welfare benefit plan which is a multiple employer welfare arrangement, in addition to this subchapter, any law of any State which regulates insurance may paply to the extent not inconsistent with the preceding sections of this subchapter." (Emphasis added.)

The term "multiple employer welfare arrangement" or "MEWA" is defined at 29 United States Code section 1002(40)(A) to mean "an employee welfare benefit plan, or any other arrangement (other than an employee welfare benefit plan), which is established or maintained for the purpose of offering or providing any benefit described in paragraph (1) to the employees of two or more employers (including one or more self-employed individuals), or to their beneficiaries, . . . ."

What is the impact of this legislation aimed at regulating MEWA's? The Commissioner asserts that state insurance laws are now wholly applicable to entities such as ABT.

The MEWA legislation was contained in Public Law 97-473 and became effective on January 14, 1983. The legislative history of this legislation is instructive. It is set forth at page 4604 of the U.S. Code Congressional and Administrative News (1982) and it provides as follows:

"5. Waiver of Preemption in Case of Multiple Employer Welfare Arrangements

"Present Law

"The Employee Retirement Income Security Act of 1974 (ERISA) provides comprehensive rules relating to employee benefit plans, including plans providing health benefits to employees. The Act (sec. 514(a)) generally supersedes State laws insofar as they relate to employee benefit plans.

"House Bill

"The provision generally exempts certain multiple employer welfare arrangement from the ERISA preemption provision. Under the provision, a multiple employer welfare arrangement is any plan or other arrangement established to offer welfare benefits, such as health insurance, to the employees of two or more employers. However, it continues preemption with respect to State law applying to any plan maintained pursuant to a collective bargaining agreement or maintained by a tax exempt rural electric cooperative.

"In the case of a fully insured multiple employer welfare arrangement, the provision exempts from ERISA preemption any State laws that require the maintenance of specified levels of reserves and contributions in order for such an arrangement to be considered adequately funded.

"In the case of a multiple employer welfare arrangement that is not fully insured, the provision exempts from ERISA preemption any State laws that regulate insurance. Notwithstanding this provision, the Secretary is authorized to determine the extent to which the ERISA preemption provision will be applied to a multiple employer welfare arrangement that is not fully insured. The Secretary's determination may be made on a case-by-case basis or a class basis.

"The provision is effective on the date of enactment.

"No provision.

"Conference agreement

"The conference agreement follows the House bill." (Emphasis added.)

Congress has, therefore, expressed its unequivocal intent that MFWA'S be subject to state regulation. While the Commissioner contends that ABT is not an employee welfare benefit plan, it would still be subject to state regulation even if it were a qualified plan.

## II

## INSURANCE CODE § 1065.2 IS NOT VIOLATIVE OF DUE PROCESS

By its terms, Insurance Code § 1065.2 provides in pertinent part that:

"(a) Whenever it appears to the Commissioner that any conduct, condition or ground set forth in Section 1065.1 exists, and that irreparable loss and injury to the property and business of a person specified in Section 1010 has occurred or may occur unless the commissioner acts immediately, the commissioner may,

> *without notice, and before hearing, issue and cause to be served upon such person an order requiring such person to forthwith cease and desist from engaging further in the acts, practices or transactions which are causing such conduct, condition or ground to exist*.
>
> (b) At the same time an order is served pursuant to subdivision (a) of this section the Commissioner shall issue and also serve upon the person a notice of hearing to be held at a time and place fixed therein which shall not be less than 20 or more than 30 days after the service thereof. The notice shall contain a statement of the conduct, condition or ground which the commissioner deems violative of the provisions of Section 1065.1." (Emphasis added.)

The foregoing code provision basically permits the Commissioner, under specified conditions, to issue an immediate cease and desist order and to thereafter provide an administrative hearing to the affected person. Such a procedure wholly comports with the requirements of due process.

While there are no reported cases under Insurance Code § 1065.2, there manifestly exists a clear line of authority standing for the proposition that summary action is appropriate and justified where exigent circumstances are present. In its decision in *Fahey* v. *Mallonee* (1947) 332 U.S. 245, the United States Supreme Court dealt with due process requirements relating to the closing of a savings and loan association by federal authorities. *Fahey* held that, in the foregoing context, the summary taking of property without any prior hearing whatsoever is fully consistent with the requirements of due process. Subsequently, the Supreme Court has repeatedly recognized that there exists a distinct category of "extraordinary situations" in which summary taking is constitutional and of which Fahey is an example. (See Boddie v. Connecticut (1971) 401 U.S. 371, 379; Bell v. Burson (1971) 402 U.S. 535, 542; Fuentes v. Shevin (1972) 407 U.S. 67, 90; Sniadach v. Family Finance Corp. (1969) 395 U.S. 337, 339.)

The Insurance Commissioner is a government official. In the performance of her duties in protecting the public, she investigated plaintiffs and determined that they were operating as unlicensed insurers in a hazardous manner which could have led to irrevocable loss and injury if allowed to continue. (See pages 4, 5 and 6 of the cease and desist order.) Under these circumstances, she exercised her authority under § 1065.2 to issue an immediate order coupled with a subsequent hearing. As an alternative remedy, the Commissioner could have summarily placed plaintiffs into conservatorship under Insurance Code § 1011. A person placed into conservatorship can thereafter obtain a judicial hearing under Insurance Code § 1012. It has been expressly held that such a procedure does not violate due process. (Rhode Island Ins. Co. v. Downey (1950) 95 Cal.App.2d 220, 235-239.) Since the Commissioner could have summarily placed plaintiffs into conservatorship without violating their due process rights, the subject cease and desist order is similarly not violative of due process.

The requirements of due process are not rigid and immutable. Rather, the procedural requirements of the due process clause are universally recognized to be flexible in order to permit courts to weigh private interests against public interests in each particular case. (See Morrissey v. Brewer (1972) 408 U.S. 471.) The Commissioner was confronted here with the extraordinary situation of unlicensed insurers operating in a hazardous manner. Under these exigent circumstances, the Commissioner's order was wholly appropriate and necessary. Plaintiffs' due process rights were not violated.

## CONCLUSION

For each and all of the above stated reasons, the Insurance Commissioner requests that the plaintiffs' application for a temporary restraining order be denied.

DATED: September 26, 1989

JOHN K. VAN DE KAMP, Attorney General
of the State of California
EDMOND B. MAMER,
Supervising Deputy Attorney General
RAYMOND B. JUE,
Deputy Attorney General

Raymond B Jue
RAYMOND B. JUE
Deputy Attorney General

Attorneys for Defendant

#A/AssoBen

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SUBCOMM ON INVESTIGATIONS

MAY 18 1990

[illegible] OFFICE

**DEPARTMENT OF INSURANCE**
P. O. Box 517
Frankfort, Kentucky 40602
(502) 564-3630

**LEROY MORGAN**
COMMISSIONER

**WALLACE G. WILKINSON**
GOVERNOR

May 17, 1990

**Senate Permanent Subcommittee on Investigations**

**EXHIBIT #** 34

Hon. Sam Nunn
Chairman
Permanent Committee on Investigations
Committee on Governmental Affairs
United States Senate
Washington, D.C. 20510-6250

RE: Multiple Employer Welfare Arrangements

Dear Senator Nunn:

This letter is in response to your request for a written statement for the record of the Permanent Subcommittee on Investigations hearing held on May 15, 1990, concerning multiple employer welfare arrangements. Some refer to the current questions raised by multiple employer welfare arrangements ("MEWAs") as an emerging problem. The truth is that the problem of uninsured MEWAs is a reemerging problem. During the early 1980s, several states experienced problems with uninsured multiple employer trusts ("METs"). Millions of dollars of health care expenses went unpaid as unscrupulous MET operators collected premiums from unsuspecting employers, paid current claims out of premiums intended for future claims, became insolvent, and closed up shop. Often, the same persons reopened operations at another location.

States' attempts to suppress uninsured METs were greatly inhibited by the preemption provisions of the Employee Retirement Income Security Act ("ERISA"). The operators of uninsured METs asserted that they were operating an ERISA employee benefit plan, and, therefore, exempt from state regulation. By the time questions were resolved, the money had vanished.

In order to combat this problem, Congress adopted the Ehrlenborn-Burton Amendment to 29 U.S.C. § 1144, which created the concept of MEWAs and provided that MEWAs are subject to state insurance laws. Unfortunately, the text of the Ehrlenborn-Burton Amendment is so complex as to render it ambiguous. As problems with uninsured MEWAs reemerge, the first defense asserted by uninsured health plans is that the MEWAs are protected from state insurance laws by ERISA.

Kentucky is currently faced with an uninsured MEWA with its principal place of business in Louisville, Kentucky. This MEWA, National Business Association Trust ("NBAT") was unable to produce documentation that it is an ERISA employee benefit plan. However, this did not stop it from asserting the defense of ERISA preemption: NBAT has filed suit against the Kentucky Commissioner of Insurance and the Kentucky Department of Insurance, asserting that it is not subject to state regulation because of preemption by ERISA.

The Department has received some cooperation from the United States Department of Labor in attempting to deal with NBAT. The Department of Labor did issue an opinion stating that NBAT is a MEWA subject to state insurance laws. However, the authority of the Department of Labor is limited in that it has no licensure power over MEWAs.

The Department suggests that consideration be given to clarifying the language of 29 U.S.C. § 1144 to strengthen the hands of state insurance regulators. The Department also suggests that some type of prior approval, prior registration, or licensure be required for MEWAs. This will give regulators an opportunity to review financial arrangements before a MEWA begins operation.

In closing, the Department observes that some federal laws which provide exemptions from state insurance regulation all too often serve as an invitation to persons engaged in fraudulent business practices. The preemption provisions of 29 U.S.C. § 1144 and the Liability Risk Retention Act, 15 U.S.C. § 3901 et seq., are two examples which come readily to mind. The Department urges the Congress to give greater consideration to preventing the possibility of creating avenues for fraud when state insurance laws are preempted by federal laws.

The Department is aware of the substance of the testimony of James E. Long, Vice President of the National Association of Insurance Commissioners and the North Carolina Commissioner of Insurance, before the Subcommittee on May 15, 1990. The Department strongly supports Commissioner Long's comments.

Thank you for the opportunity to comment. Please contact me if further information is needed or if the Department may be of service in the future.

Sincerely,

Pat Watts

Patrick Watts, General Counsel
(502) 564-6032

PW/tsw

SECRETARY OF LABOR
WASHINGTON

Senate Permanent Subcommittee
on Investigations

EXHIBIT # 35

MAY 14 1990

Commissioner Earl R. Pomeroy
President
National Association of
  Insurance Commissioners
600 E. Boulevard
Bismarck, North Dakota 58505

Dear Mr. Pomeroy:

In order to underscore my personal commitment to strengthen our efforts to ensure maximum cooperation between my Department and the states in dealing with the problems relating to multiple employer welfare arrangements, I have sent the enclosed letter to each state insurance commissioner.

I am particularly appreciative of your efforts, as President of the National Association of Insurance Commissioners, to further this effort.

With my warmest regards,

Sincerely,

Elizabeth Dole

Elizabeth Dole

Enclosure

U.S. DEPARTMENT OF LABOR
SECRETARY OF LABOR
WASHINGTON, D.C.

MAY 14 1990

Commissioner Earl R. Pomeroy
President
National Association of
Insurance Commissioners
600 E. Boulevard
Bismarck, North Dakota 58505

Dear Mr. Pomeroy:

As Secretary of Labor one of my most important responsibilities is the protection of our nation's private employee benefit plan system. These programs cover the majority of American workers and their families and provide essential retirement and health care benefits. I am writing today to share with you the Department's plans for dealing with a growing problem that we share in the area of health care plans. I am speaking of the apparently growing number of multiple employer welfare arrangements (MEWAs), as distinguished from collectively bargained multiemployer plans, that are operating in an uninsured, unfunded and sometimes fraudulent manner.

We understand that MEWAs are often marketed to small businesses as a vehicle for providing affordable health insurance programs. In some instances, MEWAs may offer a viable alternative to traditional insurance. The current problems, however, are due to promoters who have sought to exploit the lack of affordable health care coverage through abusive and fraudulent practices. I know that you share my deep concern that hard working Americans not be denied the health care benefits that they believe have been provided through their employers due to such fraudulent practices. As you know, both Federal and state laws regulate MEWAs.

I am aware that the question of Federal preemption under the Employee Retirement Income Security Act (ERISA) is often viewed as an obstacle to effective enforcement by the states in this area. Although questions may have existed in the past, the 1983 amendments to ERISA resolved many of the problems by specifically granting the states authority to regulate MEWAs regardless of whether they are a "plan" under ERISA or not. I am convinced, however, that the Department can and should do more in this area. Accordingly, I instructed DOL's Pension and Welfare Benefits Administration (PWBA) to develop a program designed to assure the maximum possible cooperation and coordination of enforcement with your office. Under the program we will:

*Identical letters were sent to all state commissioners.
See attached list.

1. Conduct regional symposia on MEWAs and ERISA for the staffs of interested state and Federal agencies. Such symposia might be conducted by PWBA independently or, to the extent there is an interest, in conjunction with other Federal and state agencies and the NAIC.

2. Prepare technical assistance materials which are designed to assist the staffs of state agencies with respect to MEWAs and ERISA.

3. Pursue cooperative arrangements with appropriate state agencies pursuant to which PWBA's Area Offices will share and discuss cases opened and closed by PWBA involving MEWAs, as well as make available documents obtained with voluntary production or civil subpoena.

4. Provide expedited review of advisory opinion requests from states on the issue of whether a particular entity is a MEWA for purposes of the exception to ERISA preemption of state regulation.

5. Distribute, on a quarterly basis, copies of all advisory opinions concerning MEWAs to the Insurance Commissioners of each state.

6. Review the Form 5500 Annual Return/Report filed by employee benefit plans under ERISA to determine whether it is possible to provide a listing of MEWAs to the states.

In addition, as part of a larger enforcement package, we will soon be asking the Congress to amend ERISA to require MEWAs to file an annual registration statement with the Department. We expect that the information gathered from these filings will be especially valuable in monitoring MEWAs that do business in more than one state. It should put you in a position to act early to assure proper funding of MEWAs. It should also benefit small employers and their employees who are victims of promoters of fraudulent MEWAs.

Because of my particular concern for ERISA enforcement, I have also asked the Congress for a major budget increase for enforcement and legal staff dedicated to ERISA enforcement. The Department's request for 133 new positions will generate 1,000 new investigations annually, in both the pension and welfare plan areas. With this enhancement, we will be in a better position to devote the resources necessary to deal with this apparently growing problem.

The Federal government has a responsibility to enforce vigorously our civil and criminal laws to protect the benefits of American

DEPARTMENT OF INSURANCE
State of North Carolina
P. O. BOX 26387
RALEIGH, N. C. 27611

JIM LONG
COMMISSIONER OF INSURANCE

(919) 733-7343

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JUN 04 1990
MAJORITY OFFICE

Senate Permanent Subcommittee
on Investigations
EXHIBIT # 36

June 1, 1990

Ms. Mary D. Robertson
Room SR 100
Russell Senate Office Building
Washington, D.C. 20510

Dear Ms. Robertson:

The transcript of my testimony before the U.S. Senate Permanent Subcommittee on investigations of the Committee on Governmental Affairs on May 15, 1990, is correct as published.

I would like to respond to an issue brought up in Testimony from Mr. Robert Long (page 140 of the transcript). Although Mr. Long did sit for and pass the examination to become licensed as an insurance agent in North Carolina, my Agents Services Division did not issue a license to Mr. Long, and he has been notified of our rejection of his application.

Sincerely,

Jim Long

Jim Long

JEL/BTH/tlb

workers and to punish those who would, for their own personal gain, seek to put these benefits in jeopardy. I am committed to ensuring that we meet that responsibility.

You and your colleagues throughout the country also have an essential role to play. In some ways, you are better positioned to prevent this abuse because you can seek to assure that MEWAs meet minimum financial sufficiency tests. I know that you are working diligently to use the powers you have to prevent these fraudulent arrangements from continuing to do business. I am convinced that by working together we can meet our obligations to protect the workers of this country.

I believe these initiatives represent an important step in formulating an effective state and Federal strategy in dealing with MEWAs. However, your input is essential to assess the value of our program. I would be most grateful for your views or any suggestions you may have to offer. Please let me know if you have any questions or comments on our intiatives or on what could be done in the future.

I look forward to hearing from you. I am sure that together we can address this problem effectively.

With my warm regards,

Sincerely,

Elizabeth Dole

Elizabeth Dole

Senate Permanent Subcommittee
on Investigations

EXHIBIT # 37

TheTravelers

The Travelers Companies
One Tower Square
Hartford, CT 06183

Corporate
Communications
Department

Douglas E. Quat
203 954-5970

STATEMENT BY THE TRAVELERS INSURANCE CO.

Travelers discontinued its business relationship as claims administrator for Cap Staffing on July 31, 1989 because of Cap's failure to meet the terms of its health plan contract. Travelers stopped servicing the payment of all claims for Cap Staffing as of that date.

Cap Staffing had established a self-insured health plan for its employees and contracted with Travelers to administer the program. Travelers' role was to process claims on behalf of Cap Staffing and pay claims using funds provided by Cap Staffing. Travelers was not the insurer for the health benefit plan.

In October 1989 Travelers sued Cap Staffing for failing to meet contract obligations that required Cap to adequately fund its bank account used to pay claims. In an effort to continue support for employees covered through Cap Staffing, Travelers advanced nearly $1 million of its own money to cover outstanding claims. These were funds Travelers had no legal requirement to expend.

Travelers has cooperated fully with state and federal authorities currently investigating Cap Staffing's business activities.

-30-

5/15/90

COMMONWEALTH OF VIRGINIA

STEVEN T. FOSTER
COMMISSIONER OF INSURANCE

Box 1157
RICHMOND, VA 23209
TELEPHONE: (804) 786-3741
TDD/VOICE: (804) 225-3086

STATE CORPORATION COMMISSION
BUREAU OF INSURANCE

June 12, 1990

Senate Permanent Subcommittee
on Investigations

EXHIBIT # 38

The Honorable Sam Nunn, Chairman
United States Senate
Committee on Governmental Affairs
Permanent Subcommittee on Investigations
Russell Senate Building, Room 100
Washington, DC 20510-6250

Dear Senator Nunn:

Mr. Chairman and members of the Committee, as Commissioner of Insurance for the Commonwealth of Virginia, I am pleased to have this opportunity to submit comments for the record regarding multiple employer welfare arrangements (MEWAs).

In this period of ever increasing health insurance costs, there is always someone ready to step in with a new and innovative approach to lower costs without sacrificing coverage. As Commissioner of Insurance in Virginia, I have the responsibility to be receptive to innovative new approaches while assuring adequate protection to the citizens of this Commonwealth. Unfortunately, it is also common during these times for unscrupulous individuals to take advantage of such conditions in the health insurance market for their personal gain at the expense of the general public.

As health care costs continue to climb, multiple employer welfare arrangements (MEWAs) have become an increasingly popular vehicle for controlling health care costs. The concept is quite simple. A MEWA is nothing more than a pooling of self-insured employers (and their employees). No one in government currently knows how many MEWAs exist and are operating nationally or on a state-by-state basis. What has become obvious is that the MEWA industry appears to have more than its share of fraudsters and perhaps well meaning but inept individuals running health care plans.

Why has this industry become a haven for dishonest or incompetent operators? Quite simply persons of this type are attracted to any industry where there is high cash flow, low overhead and lack of regulation at both the state and federal levels. Granted, there are statutes on the books of both the federal government and numerous states that purport to establish the regulatory framework necessary to properly protect the citizenry. However, the dishonest element looks beyond the words on paper to the actual regulatory efforts being exerted. They are quick to realize that although both the federal and state governments may regulate these entities, such a system of overlapping authorities creates confusion and a misdirected focus of the regulatory effort. The dishonest operators use such confusion to their advantage. Knowing that currently the federal government is not actively regulating these plans effectively, these individuals will quickly and persistently claim to enjoy exemption from any state regulation by virtue of the Employee Retirement Income Security Act (ERISA), when a state attempts to exert its regulatory authority. The arguments on their face appear to have some merit. When the Department of Labor (DOL) is asked by a state to judge the merits of a particular preemption argument, DOL staff responds verbally, but seldom, if ever, in written form. From conversations which my staff has had with individuals at DOL, DOL has not taken formal written positions on federal pre-emption of state law for MEWAS, though DOL staff is quick to acknowledge state authority - yet again only verbally. Specifics, however, remain elusive. For example, my staff has been told DOL has not formally interpreted statutory language relating to the states' ability to regulate to the extent not inconsistent with Title One of ERISA. The states are not experts on interpreting federal statutes and look for written guidance from DOL without success. It is my understanding that ERISA provides for DOL to issue regulations and specific exemptions of plans, yet to date no regulations or specific exemptions are in place. As far as DOL opinions as to whether a plan is a MEWA and subject to state regulation, we understand that there have been less than 100 administrative opinions issued since approximately 1977. Most of these are stock-answer responses, which are general in nature and, in some instances, unresponsive to the questions asked. In addition, the DOL will not judge the factual situation of a particular plan. Response time in the past for DOL administrative opinions has been protracted, although it appears that there is now a valid effort on the part of DOL to be more timely in its responses to states.

How does all of this play into the hands of the dishonest or incompetent operator? Quite honestly, when a state asks for information, the plan claims federal pre-emption and either respectfully declines to submit information or delays such submission for numerous months. In addition, there is no requirement that a plan (MEWA) has to be submitted to the DOL before it can operate, and the plans usually do not submit requests themselves. States are reluctant to act without a representation from the federal government that they have the authority to act. The state acts to get the documentation from the plan necessary to make its own request for opinion to DOL. Because these plans can be structured in just about any way imaginable, there is seldom the secure feeling that whatever has been submitted to DOL for review is the definitive plan. A request for opinion is made and all the pertinent questions necessary to the resolution are asked. After several months (currently), a canned response is received which does not address the specific questions but usually states that a plan is a MEWA subject to some level of state regulation.

It is important to remember that during this whole process the plan has been operating, collecting premiums or contributions and hopefully paying claims. At very least, you may be sure that the principals have been paid handsomely for their participation. In the worst case, they have mismanaged the funds, paid only small claims, and siphoned off a larger portion of the proceeds for themselves. By the time it is determined that the state does have the authority to regulate, the plan has in many cases generated large liabilities to its members for claims and has insufficient cash to fund these liabilities. At this point the plan either ceases to exist or is placed into receivership.

Who ultimately suffers from this scenario? The individual employee and his family. It must be remembered that it is the employer that negotiates coverage with the MEWA often based on price alone. His employees assume they have insurance coverage on a group basis and think no more about it until their claims go unpaid.

Many times, when employees realize what they have as coverage, it is too late. They have amassed large medical bills which the plan is unable to pay. Individual employees have often agreed with the physician or hospital before treatment to be responsible for any amounts which "insurance" doesn't pay and face personal hardship or even bankruptcy because of the lack of consistent full-fledged regulation.

What is the solution? As DOL has stated, no one seems to be able to get a handle on how many MEWAs exist. Above all, registration of all plans with the federal government should be required prior to the offering of coverage with DOL issuing to each registrant prior to operation a determination of who will have regulatory oversight, the state or the federal government. I believe that dual regulation of these entities serves no useful purpose other than to frustrate effective regulation. Since the states are charged with regulating other insurance entities, I believe that the states should have primary regulatory responsibility. DOL should be available to work with the states in enforcing the laws on a multijurisdictional basis and assist in the investigation, apprehension and prosecution of the dishonest or incompetent organizer or organization.

Currently, it appears difficult to have any penalties assessable at the federal level to offset the exposure of its insured members. A mechanism should be in place to require such fines and penalties to be made available first to insureds, perhaps through the state receiver.

Most importantly, it is imperative that not only the state and federal governments work more closely together to solve this problem but that in addition, disharmony between individuals and divisions inside the respective agencies be kept to a minimum with all energies focused on solving the problem at hand for the benefit of the citizenry. Where there is no chink in the armor and no perceived discord among the regulatory bodies involved, there is little weakness to be exploited by the dishonest person.

If you should have any questions or would desire my further comments, I would be pleased to respond to your inquires.

Sincerely,

Steven T. Foster
Commissioner of Insurance

Senate Permanent Subcommittee
on Investigations

EXHIBIT # 39

Testimony of

PATRICIA RUTH DONOVAN PETERSEN

DEPUTY INSURANCE COMMISSIONER

STATE OF WASHINGTON

ON

# REGULATION OF MULTIPLE EMPLOYER WELFARE ARRANGEMENTS BY THE U.S. DEPARTMENT OF LABOR AND STATES

before the

Committee on Governmental Affairs
Permanent Subcommittee on Investigations

United States Senate

hearing entitled

FRAUD AND ABUSE IN EMPLOYER SPONSORED HEALTH BENEFITS PLANS

May 15, 1990

Washington, D.C.

Chairman Nunn and members of the Permanent Subcommittee on Investigations, on behalf of both Insurance Commissioner Dick Marquardt and myself, thank you very much for inviting me to present this testimony to you.

I am Patricia Petersen. For six years I have been employed in the position of Deputy Insurance Commissioner for Washington State. In this position, I have been responsible for issues arising under the federal Employee Retirement Income Security Act ("ERISA"), 29 USC Sec. 1001 et seq., which affects state as well as federal jurisdiction. I am an attorney, I have previously practiced business law privately and prior to my current employment, I have held a number of state and federal governmental posts.

I attach for your information (Attachment 1, with Exhibits) a copy of testimony which I presented before the Subcommittee on Legislation and National Security, U.S. House of Representatives, on December 12, 1989. This statement presents a detailed account of Washington State's experience with alleged Multiple Employer Welfare Arrangements ("MEWAs") and the U.S. Department of Labor. Since this testimony was presented, Washington State has taken action against several more alleged MEWAs. We have also discovered that some of the operators of MEWAs which were specifically detailed in my previous testimony have been working to set up similar MEWAs in

Montana and probably other states. This is still a major national problem which knows no state boundaries and will only grow worse before it grows better. For this reason, I have been very heartened to see there has been more discussion opened up between the Pension Welfare Benefit Administration, U.S. Department of Labor ("PWBA"), the Office of the Inspector General, U.S. Department of Labor ("OIG"), the U.S. Congress and the states. These efforts can only inure to the benefit of all of us and of the thousands and thousands of innocent citizens who have been, and continue to be, seriouslyn harmed by this problem which has been caused, in part, by lack of communication and lack of cooperation between PWBA, OIG and the states as well as by the unclear wording of ERISA. I hope that we have come to the point where we can now all acknowledge that these deficiencies exist and we can now work together toward our common goals.

It is also heartening to see the specific recommendations for action presented at this hearing, including:

1. The proposal to set up and require a registration process within PWBA for entities which intend to offer health or other disability coverage is most well taken. This procedure should include a certification granted by PWBA to such entities prior to the time they commence solicitation of their product. This would

presumably include certain standards to be met to at least in part avoid potential problems common to this industry. This would also by its nature include a determination that the entity is, in fact, a MEWA in accord with the intent of ERISA; with this MEWA determination states can apply their specific state laws most effectively.

2. As the OIG points out, in order to most effectively police this national problem, the PWBA and OIG need to end the jurisdictional dispute which has existed between them for several years. Citizens and states have been adversely effected by this dispute as has been indicated by my previous testimony. While PWBA certainly retains the right to ceretify and be active in regulation of MEWAs, there seems to be no valid reason why the OIG, with its expertise and experience in this area, should not be also given an acknowledged and active role in policing MEWAs: The OIG has extensive experience in the use of the federal RICO statute and other criminal powers. Instead of PWBA's continual attempt to limit OIG/s activities in this area, it would appear that PWBA, OIG and the states could actually compliment each other and work well hand-in-hand. It should also be noted here that since I presented my testimony on December 12, 1989, as stated above Washington State has taken action against several more alleged MEWAs and we have continued to work to help citizens in the cases detailed in that prior testimony; still,

however, the PWBA has had no involvement at all. The OIG, on the other hand, has remained actively involved, giving us great assistance and has taken very impressive actions against alleged MEWAs in Washington State on its own.

3. As stated here by the National Association of Insurance Commissioners ("NAIC") and other states, the wording of ERISA is unclear. A statutory clarification of the language of ERISA would be helpful. Secretary Dole's letter of interpretation written recently is also helpful, but given the inevitable court case the ideal situation would certainly be a more clear statute.

4. National seminars and data banks which involve the states, PWBA and OIG together and also on individual bases are good forward steps. These recent activities are very helpful and in combination with implementation of the above recommendations can be most effective in beginning to alleviate the problems we are experiencing.

In summary, I sincerely hope those involved in this area of real tragedy have all come to realize that there has been deficiencies in general communication and federal and state notions of respective responsibilities. There have been unreasonable jurisdictional disputes. Finally, the unclear language of ERISA has been a detriment to recent efforts to correct MEWA abuse. From this point on, it is imperative that we act on the above recommendations which have been made by my respected and well-meaning fellow witnesses. This major national problem knows no state boundaries. Perhaps we will not be able to help many of the thousands and thousands of citizens who have lost millions of dollars through no fault of their own. We are obligated at this time, however, to learn from this hardship and to proceed immediately with a true spirit of cooperation - without past unnecessary territorial disputes and with keen insight and knowledge and a willingness to make necessary changes. This will serve to benefit all of us.

U.S. Department of Labor

Pension and Welfare Benefits Administration
Washington, D.C. [illegible]

Senate Permanent Subcommittee
on Investigations

EXHIBIT # 40

*April 19, 1990*

Mr. Kevin Cronin
NAIC
Hall of the States
444 N. Capitol Street, N.W.
Suite 636
Washington, D.C. 20001

Dear Mr. Cronin:

It was a pleasure meeting with you and Mr. Pomeroy on March 23 to discuss the Pension and Welfare Benefits Administration's initiatives in the area of multiple employer welfare arrangements (MEWAs).

One of the initiatives we discussed involved a review of the Form 5500 Series Annual Return/Reports for purposes identifying those information items on the Forms which may serve to identify possible MEWAs. In this regard, you and Mr. Pomeroy expressed an interest in reviewing the Forms. Copies of the 1989 Forms, instructions and related schedules are enclosed. We welcome any suggestions you may have in this area.

On the basis of our review of the Forms, we have concluded that no single item or combination of items currently appearing on the Forms would serve to produce any meaningful, computer-generated, list of MEWAs. While a computer-generated listing might be pared-down through a manual review of the Forms and schedules, such an undertaking obviously would entail significant resources and costs, and, even then, the usefulness of the resulting listing to the States is questionable inasmuch as such a paring-down would, among other things, involve a number of subjective determinations on the part of the reviewers. Moreover, as you will note from the Forms and instructions, very little information is actually required to be filed with respect to plans with fewer than 100 participants, which we believe would be the largest category of plans opting to provide benefits through a MEWA. For these reasons, we believe that our legislative proposal to require MEWAs to file a registration-type report with the Department represents the most effective and efficient means by which to obtain useful MEWA information for the States. As indicated in our meeting, we welcome any suggestions that the NAIC may have with respect to information which might be included in such a MEWA registration report.

By way of an update, we are continuing work on our MEWA/ERISA technical assistance materials and hope to have a draft suitable for distribution in the not too distant future. I will transmit a copy to you for review as soon as the draft is completed.

In the interim, should you have any questions concerning the Forms or any other matters, please do not hesitate to contact me.

Sincerely,

Robert J. Doyle
Director of Regulations
and Interpretations

Enclosures

**U.S. Department of Labor** [illegible]

April 3, 1990

Commissioner Earl R. Pomeroy
President, National Association
  of Insurance Commissioners
North Dakota Department of Insurance
600 E. Boulevard
Bismark, North Dakota 58505-0320

Dear Commissioner Pomeroy:

Thank you for taking time out of your busy schedule to meet with us concerning the Pension and Welfare Benefit Administration's (PWBA) proposed initiatives in the area of multiple employer welfare arrangements (MEWAs). We were very pleased with your support for our intiatives and look forward to working with you and the NAIC in effectuating these initiatives in a meaningful and productive manner. In this regard, we will be following up with Mr. Cronin concerning our review of the Form 5500 Series as a possble informational source for identifying MEWAs and our preparation of informational materials which, among other things, are intended to clarify the application of ERISA to MEWAs.

We were also pleased with your interest in our proposed legislative initiative which would require MEWAs to register with the Department of Labor. As indicated in our meeting, we are very interested in receiving any recommendations that you and the NAIC may have with respect to information that would be useful to the States regarding MEWAs which might be included in such a registration-type statement.

With regard to the Department's discussion of the MEWA legislative initiative, which was included as an attachment to a March 20 letter from Deputy Secretary DeArment to Congressman Tom Lantos and a copy of which was furnished to you at our meeting, we should note that reference is erroneously made to "multi-employer" trust arrangements, rather than "multiple" employer trust arrangements. This regretable mis-reference has raised concerns on the part of a number of "multi-employer" plans, which are plans maintained pursuant to collective bargaining agreements and, thus, not "multiple employer welfare arrangements" subject to State insurance regulation. The multi-employer plans are concerned that the mis-reference in our letter may, in fact, lead some State insurance regulators to mistakingly seek to impose state insurance laws against bona fide collectively bargained plans.

Again, thank you for your support and assistance.

Sincerely,

Alan D. Lebowitz
Deputy Assistant Secretary
for Program Operations

cc: Kevin Cronin
NAIC
Hall of the States
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**U.S. Department of Labor**

Pension and Welfare Benefits Administration
Washington D.C. 20210

FEB 13 1990

Commissioner Earl R. Pomeroy
President, National Association
of Insurance Commissioners
North Dakota Department of Insurance
600 E. Boulevard
Bismarck, North Dakota 58505-0320

Dear Commissioner Pomeroy:

The purpose of this letter is to explore with the National Association of Insurance Commissioners means by which the Department of Labor and, in particular, the Pension and Welfare Benefits Administration (PWBA), can assist state Insurance Commissioners in dealing with Multiple Employer Welfare Arrangements (MEWAs), also referred to as multiple employer trusts or METs.

PWBA is responsible for administering and enforcing the provisions of the Title I of the Employee Retirement Income Security Act (ERISA). Among other things, Title I of ERISA establishes reporting, disclosure and fiduciary standards for private-sector employee pension benefit plans and employee welfare benefit plans (e.g., plans providing medical, hospital, surgical and similar benefits). ERISA also contains very broad preemption provisions which generally reserve regulatory and enforcement authority over employee benefit plans to the Federal government. However, recognizing that it was both appropriate and important that states be able to establish, apply and enforce state insurance laws over MEWAs, Congress enacted a special exception to ERISA's preemption provisions in 1983 which effectively removed Federal preemption as an obstacle to state regulation of MEWAs. In this regard we should note that, unlike many state insurance laws, ERISA does not contain any funding, reserve or contribution requirements which would be applicable to MEWAs.

It appears from our contacts with various states, as well as from testimony presented in Congressional hearings by state representatives, that promoters of MEWAs may, despite the 1983 amendments to ERISA, be continuing to frustrate state regulatory efforts by raising Federal preemption as an issue. We are concerned that MEWAs are too often woefully underfunded and, therefore, unable to pay claims, or worse, they are operated by individuals who deplete the funds through extraordinarily high administrative fees or outright embezzlement. Obviously, noncompliance with applicable state and Federal regulatory standards substantially increases the risk of unpaid medical and hospital claims for the many participants and beneficiaries who may be covered by such MEWAs.

In an effort to address the jurisdictional and other issues relating to MEWAs, the PWBA is preparing to undertake the following initiatives which are intended to assist states in dealing with MEWAs:

1. Conduct regional symposia on MEWAs and ERISA for the staffs of interested state and Federal agencies. Such symposia could be conducted by PWBA independently or, in conjunction with other Federal and state agencies, and the NAIC, to the extent there is an interest in participating in the symposia.

2. Prepare technical assistance materials which are designed to assist the staffs of state agencies with respect to MEWAs and ERISA.

3. Pursue cooperative arrangements with appropriate state agencies pursuant to which PWBA's Area Offices will share and discuss cases opened and closed by PWBA involving MEWAs, as well as make available documents obtained with voluntary production or civil subpoena.

4. Provide expedited review of advisory opinion requests from states on the issue of whether a particular entity is a MEWA for purposes of the exception to ERISA preemption of state regulation.

5. Distribute, on a quarterly basis, copies of all advisory opinions concerning MEWAs to the Insurance Commissioners of each state.

6. Review the Form 5500 Annual Return/Report filed by employee benefit plans under ERISA and the ERISA database system to determine whether it is possible to identify MEWAs through the annual reporting process. If such identification is possible, PWBA will furnish states with a listing of the identified MEWAs.

We believe the above initiatives represent an important first step in formulating a more effective and efficient state and Federal strategy for dealing with MEWAs. However, we also believe that, as state Insurance Commissioners, the membership of the NAIC may be in the best position to assess the value of these initiatives. For this reason, we are very interested in obtaining the views of the NAIC, as well as any suggestions which you or your members may have in this area.

In the interim, should you have any questions or wish to meet to discuss the subject further, please do not hesitate to contact me at (202) 523-9048.

Sincerely,

Alan D. Lebowitz
Deputy Assistant Secretary
  for Program Operations

cc: Commissioner James E. Long
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  of Insurance Commissioners
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*National
Association
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February 23, 1990

Mr. Alan D. Lebowitz
Deputy Assistant Secretary
 for Program Operations
United States Department of Labor
Pension and Welfare Benefits Administration
Washington, DC 20210

Dear Mr. Lebowitz:

This is in response to your letter of February 13 in which you offered to explore means by which the Department of Labor can assist state insurance commissioners in dealing with multiple employer welfare arrangements. The National Association of Insurance Commissioners (NAIC) is encouraged by your willingness to establish a liaison between our two entities and the states. The initiatives which you outlined in your letter were identified at the seminar conducted in Atlanta, Georgia on October 4 and 5 and would be greatly welcomed by the state insurance commissioners, as was evidenced that day.

1. Mr. John Keene has accepted our invitation to appear at the continuing legal education seminar scheduled for March 24 in Salt Lake City. Additional educational efforts such as the regional symposia are certainly an area which we would like to pursue.

2. The preparation of technical assistance materials is a project we are developing and welcome the inclusion of additional materials.

3. The establishment of contact persons within your organizations that we could share with the state insurance departments is a suggestion raised at the Atlanta meeting which would be of great benefit to the state insurance departments. Additionally, the availability of documents from your agencies to assist in valuation of jurisdictional issues by state insurance departments would also be of assistance.

4. The issuance of advisory opinions is one of the areas identified in Atlanta as a problem area because entities claiming ERISA preemption are generally hesitant to initiate and produce opinions from your division proving their exemption. Providing expedited review of an application requested by an insurance department would be of assistance to the state insurance departments.

5. Distribution on a quarterly basis would be of great assistance to the state insurance departments.

6. The Form 5500 has been an area of frustration for the state insurance departments because the form's filing and review process as we understand it is backlogged and is of limited use once it becomes outdated. Identification of MEWAs through the standard reporting process is one which we would like to pursue. Perhaps we can explore the possibility of generating more opinions at the request of state insurance departments and work to streamline the process.

The NAIC would like to meet to discuss these ideas further. We may be able to schedule such a meeting in conjunction with a visit to Washington, D.C. on other matters. Please contact Sandra Gilfillan at the NAIC to coordinate such a visit.

Sincerely,

Earl R. Pomeroy
President
National Association of Insurance Commissioners

ERP/bkh

cc: Commissioner Jim Long

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U.S. Department of Labor

Assistant Secretary for
Pension and Welfare Benefits
Washington, D.C. 20210

The Honorable William J. Hughes
Acting Chairman
Subcommittee on Retirement
and Employment
Select Committee on Aging
U.S. House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

This is in response to your request for a clarification of certain questions raised during the November 15, 1989 hearing of the Subcommittee on Retirement and Employment, entitled "Who's Minding Your Pension." In general, the questions posed in your letter relate to multiple employer welfare arrangements (MEWAs) and the Department's responsibilities and activities under the Employee Retirement Income Security Act (ERISA) with respect to them. We welcome the opportunity to provide the requested clarifications and we hope that our responses will assist you and the Subcommittee, as well as serve to eliminate some of the confusion evidenced in the testimony before the Subcommittee relative to the ability of the states to effectively regulate MEWAs.

Prior to addressing your specific questions, however, we would like to share with you and the Subcommittee some of the initiatives which the Pension and Welfare Benefits Administration (PWBA) is currently undertaking in an effort to assist states in dealing with MEWAs. First, we are in the process of assessing the extent to which there may be interest on the part of state insurance commissioners and others in regional symposia on MEWAs. Such symposia could be conducted by PWBA independently or in conjunction with other Federal and state agencies. Second, we are in the process of completing work on technical assistance materials which are designed to assist the staffs of state agencies with respect to MEWAs and ERISA. Third, PWBA Area Offices are being directed to pursue cooperative arrangements with states pursuant to which the Offices would share and discuss cases opened or closed by PWBA involving MEWAs, as well as make available documents obtained with voluntary production or pursuant to a civil subpoena. Fourth, we have established as a priority the provision of expedited reviews of advisory opinion requests from states on the issue of whether a particular entity is a MEWA for purposes of the exception to ERISA preemption of state regulation. Fifth, we will be distributing, on a quarterly basis, copies of all advisory opinions concerning MEWAs to the Insurance Commissioners of each state. Finally, we are undertaking a review of the Form 5500 Series Annual Report and our new ERISA database system to determine the extent to which MEWAs might be identified through the annual reporting process. If such identification can be made, a listing of identified MEWAs or possible MEWAs would be furnished to the states.

We believe the above initiatives represent an important step in formulating a more effective and efficient state and Federal strategy for dealing with MEWAs.

The following is a restatement of your questions and our responses:

1) Does the Department have jurisdiction over monitoring and enforcing MEWAs under the provisions of ERISA?

In general, the Department of Labor has concurrent jurisdiction with the states over "multiple employer welfare arrangements" (MEWAs). As defined in section 3(40) of Title I of ERISA, the term "multiple employer welfare arrangement" includes both "employee welfare benefit plans" and non-employee benefit plan arrangements.

Under Title I of ERISA, the Department generally has regulatory and enforcement authority with respect to employee pension and welfare benefit plans (e.g., health, medical, surgical, and hospital plans) described in sections 3(2) and 3(1) of ERISA. It is important to note that, unlike pension plans, welfare plans are not subject to the participation, vesting or funding standards, nor does ERISA require these plans to maintain specific levels of reserves or minimum levels of contributions. The Department's regulatory and enforcement authority over employee welfare benefit plans is, therefore, essentially limited to establishing standards under, and enforcing compliance with, the reporting and disclosure provisions of Part 1, the fiduciary responsibility provisions of Part 4, the claims procedure provisions of Part 5, and the continuation coverage provisions of Part 6 of Title I of ERISA.

As you know, ERISA contains very broad preemption provisions which generally reserve regulatory and enforcement authority over employee benefit plans to the Federal government. However, as discussed below, ERISA was amended in 1983 to give the states the ability to regulate MEWAs, whether or not the MEWA is an employee benefit plan under ERISA.

Prior to 1983, many states expressed frustration in their efforts to regulate what were commonly referred to as "multiple employer trusts" or "METs" by the claims of MET promoters that the MET is an ERISA-covered employee benefit plan and, therefore, protected against state regulation under ERISA's preemption provisions. In many cases states felt compelled to seek an advisory opinion from the Department or go to court, or both, in order to resolve the issue as to whether the particular MET constituted an employee benefit plan covered by ERISA. While virtually all of the METs with respect to which advisory opinions were sought were determined not to be ERISA-covered employee benefit plans, there continued to be a great deal of confusion, if not reluctance, on the part of some states to exercise their authority to regulate METs.

Recognizing that it was both appropriate and important that states be able to establish, apply, and enforce state insurance laws over METs, Congress attempted to facilitate state regulation and enforcement by effectively eliminating ERISA preemption as an obstacle to state regulation of METs. These amendments, enacted on January 14, 1983 as part of Public Law 97-473, provided an exception to ERISA preemption for "MEWAs".

Under ERISA the Department is responsible for ensuring, among other things, that employee benefit plans are operated in a proper and prudent manner. The Department, however, does not have direct regulatory authority over insurance companies, insurance services, or insurance organizations, except in their capacity as providers of services to employee benefit plans. Accordingly, while the Department may pursue enforcement of ERISA standards against MEWAs in their capacity as service providers to plans, such action is considerably different from and often more limited than the remedies generally available to the states under their insurance laws.

Finally, under ERISA the Secretary may prescribe regulations which exempt, on an individual or class basis, some MEWAs from the application of state insurance laws. The Department has not, to date, received any information which would lead us to conclude that any such exemption, individual or class, is either appropriate or necessary. Accordingly, there should be no ERISA impediment to the application of state insurance laws to MEWAs which are not fully insured.

2) Does the Department of Labor have a process for evaluating whether particular MEWAs are underfunded or are operating fraudulently? If so, are these evaluations provided to the states?

The Department does not have a process _per se_ for evaluating whether a MEWA is underfunded or operating fraudulently. However, in the course of investigating, detecting and correcting fiduciary violations, the PWBA, in accordance with its ERISA Enforcement Strategy Implementation Plan, is devoting significant resources to the investigation of service provider arrangements with employee benefit plans, which includes arrangements with MEWAs. A number of PWBA Area Offices have entered into formal agreements for the sharing of MEWA information, and other Offices maintain contacts and conduct informal discussions with state officials concerning MEWAs.

3) What steps have been taken to help ensure that consumers are not subject to fraudulent schemes and unlawful MEWA operators?

As indicated above, PWBA's Area Offices have attempted to maintain open communications with appropriate state agencies concerning MEWAs. As discussed more fully under question 4, the Department has conducted a number of investigations of MEWAs and, where ERISA violations have been identified, corrective action has been sought. In addition, PWBA has for several years been furnishing to the insurance commissioners of each state copies of advisory opinions issued concerning MEWAs. Also, as noted earlier, PWBA is currently reviewing the annual report forms required to be filed by employee benefit plans (the Form 5500 Series) in an effort to determine whether it is possible to identify MEWAs through the annual report filings. If it is possible to identify MEWAs through the annual report, it is anticipated that a listing of the identified MEWAs would be made available to the states. We believe that maintaining open communications and sharing information between the Department and the appropriate state agencies represent steps which, in conjunction with the pursuit of appropriate state and/or Federal remedies, will reduce the number of fraudulent and unlawful MEWAs.

4) Has the Department investigated or prosecuted any MEWA providers for fraudulent practices or violations of ERISA during the past three years?

Yes. During calendar years 1987, 1988 and 1989, PWBA has conducted 38 investigations involving MEWAs specifically and a number of other investigations involving various service providers to MEWAs. During this period, 19 investigations were closed as a result of obtaining voluntary compliance or determining that no ERISA violations had taken place. PWBA currently has 18 investigations which are open involving MEWAs, some of which are criminal investigations. One case is currently being litigated in U.S. District Court.

5) To what extent has the Department of Labor coordinated with state agencies to prevent unlawful MEWA providers from operating? How has the Department of Labor assisted the states with ERISA enforcement of MEWAs?

As indicated in our responses to questions 2 and 3, above, the Department has attempted to maintain open communications and to share information with the appropriate state agencies regarding MEWAs. Our efforts in this regard are exemplified by the following actions undertaken by various PWBA field offices. The Atlanta Area Office has met with all of the insurance commissioners (or members of their staffs) of the states within its jurisdiction to discuss issues of mutual concern, and participates with the State of Georgia Insurance Department on a law enforcement coordinating committee designed to share information and conduct joint investigations. The Dallas Area Office has had an active involvement with the State of Texas' Unauthorized Insurance Division. The Chicago Area Office has for a number of years had on-going contacts with the state insurance regulators from both Wisconsin and Illinois, which includes providing information to insurance investigators regarding the activities of entities operating as unauthorized insurance companies. The Boston Area Office has had continuous discussions with the insurance commissioners of the various states within their jurisdiction in an effort to coordinate and exchange information of mutual interest concerning MEWAs. The Los Angeles Area Office has actively coordinated with the State of California's Department of Insurance and attends quarterly meetings of their MET Task Force. The Los Angeles Area Office has also made a commitment to provide a half-day training session on ERISA for the State of California's Department of Insurance staff. The San Francisco Area Office has also been active in the State of California's MET Task Force. In this regard, both the Area Director and the Deputy Area Director of the San Francisco Office have met with the California Insurance Commissioner and the department's chief investigator to discuss enforcement strategy and coordination activities.

Please be assured that the Department is committed to both continuing and promoting this policy of open communications and information sharing with appropriate state agencies through PWBA's Area Offices.

In addition, the Area Offices, as well as the National Office of PWBA have been and continue to be available to provide technical guidance and assistance to the states regarding the provisions of ERISA and the authority of the states to enforce state insurance laws with respect to MEWAs. In this regard, the Department, in an effort to facilitate state action relative to MEWAs, frequently provides state insurance commissioners and other state officials with advisory opinions concerning the status of a particular MEWA under ERISA and the application of ERISA's preemption provisions to such entities. Most recently, advisory opinions relating to MEWAs were furnished to the California

Attorney General's Office (December 7, 1989), the Georgia Insurance Commissioner's Office (December 12, 1989), and the Texas Board of Insurance (December 22, 1989).

6) How has the Department of Labor responded to the Georgia Insurance Department's request for assistance in monitoring and enforcing MEWA's, and, in particular, with investigating the National Business Association Trust?

PWBA and, in particular, PWBA's Atlanta Area Office has attempted to be responsive to all requests from the Georgia Insurance Department relating to MEWAs. With regard to the National Business Association Trust (NBAT), the Department issued an advisory opinion to Mr. L. J. Darter, an enforcement officer with the Office of Commissioner of Insurance for the State of Georgia on December 12, 1989 concluding that the NBAT was a MEWA, as defined in ERISA section 3(40) and, therefore, the exception to preemption under ERISA section 514(b)(6) applies, whether or not NBAT is an ERISA-covered plan. Therefore, ERISA would not be an impediment to the State of Georgia exercising jurisdiction over the NBAT. This opinion was issued in response to a request for guidance from the Georgia Insurance Commissioner's Office with respect to the status of the NBAT under ERISA. We are unaware of any request for assistance in investigating the NBAT.

7) How has the Department of Labor responded to the Washington State Insurance Department's request for assistance in monitoring and enforcing MEWAs?

We understand that PWBA's Seattle District Office has provided extensive assistance to the Washington State Insurance Department with respect to MEWAs. We have reviewed the written testimony of Ms. Patricia Peterson, Deputy Insurance Commissioner for the State of Washington, submitted for purposes of your Committee's November 15, 1989 hearing. In Ms. Peterson's testimony, she references two cases in which she sought the assistance of the Department. While we cannot speak to her dealings with the staff of the Office of the Inspector General, we have determined that PWBA's Seattle District Office did provide all the assistance which they were capable of providing. With regard to one of the cases, the District Office was conducting an investigation into the activities of the MEWA at the time Ms. Peterson contacted that Office. Ms. Peterson was apprised of the investigation and of the fact that, under the 1983 MEWA amendments to ERISA, there were no ERISA impediments to the State pursuing its own enforcement actions relative to the MEWA under state insurance laws. Ms. Peterson was also apprised that the remedies available under ERISA would not accommodate her concerns with regard to the MEWA's continued operation. The PWBA District Office ultimately concluded, on the basis of its investigation, that there was no financial data or other evidence substantiating ERISA or criminal violations by the MEWA enforceable by PWBA. However, the State did issue a Cease and Desist Order against the MEWA under state law. With respect to the other case referred to by Ms. Peterson, the PWBA District Office is continuing its investigation of the matter.

Again, we hope this information is of assistance to you and the Subcommittee. Should you have any further questions, please do not hesitate to contact me.

Sincerely,

DAVID GEORGE BALL